MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

SUPPLEMENTAL INSTRUCTIONS FOR 837 ENCOUNTER AND QUALITY IMPROVEMENT (QI) DATA SUBMISSION FOR SUBSTANCE ABUSE COORDINATING AGENCIES

October 2002

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February 18, 2003 revisions to the Supplemental Instructions for 837 Encounter and QI Data Submission for Substance Abuse Coordinating Agencies include:

Section 2.4

- "Implementation Timeline", page 5 – Updated the timeline

Section 2.10

- "Encounter Data Elements", pages 14 - 16 – Updated the financial data requirements

Section 3.3 – Quality Improvement (QI) Data Reporting Implementation Timeline, page 18 – Updated the timeline

Appendix B

- Encounter Error Listing – Updated with 02/19/03 Encounter Error List

Appendix C

- 837 Encounter Error Return File Layout & Business Rule Considerations
    - Business Rule Considerations included

Appendix D

- Substance Abuse Quality Improvement File Layout
    - Updated Quality Improvement File Layouts
    - Payer Identifier Numbers included

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1.0 Introduction

The Michigan Department of Community Health (MDCH) requires that Substance Abuse Coordinating Agencies (CAs) report encounters and quality improvement (QI) data for every consumer served by the CA. The Reporting Requirements can be found in Appendix A. Encounter reporting is required no matter what the payment arrangement with the provider (i.e., fee-for-service, per diem, case rate, sub-capitation, net cost contract, etc.).

Historically CAs have been submitting activity and demographic data using a proprietary format. As MDCH moves towards meeting the mandates set forth under the Health Insurance Portability and Accountability Act (HIPAA), many national standards for health care transactions are being adopted. As a result MDCH is implementing a standardized format for encounter (activity) data reporting. MDCH will require that encounters be submitted in the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837, version 4010, Professional, Institutional, and Dental Healthcare Claim formats. MDCH will use the provider-to-payer-to-payer coordination of benefits (COB) data model for encounter reporting. In addition, CAs will be required to continue to report demographic, or quality improvement (QI) data, using essentially the same format and process they have been.

The purpose of these instructions is to provide guidelines to CAs for submitting both encounter and QI data. The information provided in this manual that is specific to encounter data reporting is intended to supplement information contained in the ANSI ASC X12N 837 Implementation Guides. The Implementation Guides must be adhered to for creating 837 encounter transactions.

2.0 837 Encounter Data Reporting

2.1 HIPAA Background

In August 1996, the United States Congress adopted the Health Insurance Portability and Accountability Act (HIPAA). The Act includes Administrative Simplification components with provisions to improve the efficiency and effectiveness of the health care system by establishing standards for the electronic exchange of certain administrative and financial transactions and to protect the security and privacy of transmitted health information.

A federal regulation pertaining to transaction standards and code sets was adopted in August 2000. This regulation mandates the use of electronic data interchange (EDI) standard transactions for many of the more common communications used in health care administration, as well as the use of standard code sets. The transaction standards and code sets regulation has an effective date of October 2002. Subsequent legislation allows the effective date to be extended to provide more time to covered entities to be fully compliant. Entities that request extensions to the effective date for transactions and code sets will have until October 2003 to implement the regulation**.**

It is important to note that while an extension allows the CA increased time to meet the transaction and code set mandates set forth by HIPAA, MDCH is implementing the new ASC X12N 837 version 4010 format for encounters effective with dates of service on or after October 1, 2002. Contracted entities will be required to meet these requirements as outlined in their contracts with MDCH.

2.2 Encounter Data Reporting Format

Beginning with services incurred on or after October 1, 2002, CAs will report encounters to MDCH using the transaction sets developed by the ANSI ASC for EDI. Many EDI transaction sets are identified by numeric designations, such as the 837 healthcare claim and encounter transaction. There may also be numerous versions of an EDI transaction and the version required by MDCH for 837 encounter reporting is version 4010. Therefore, CAs reporting encounters to MDCH must use the implementation standards of the ANSI ASC X12N 837, version 4010 transactions.

In addition, the CAs are required to follow the provider-to-payer-to-payer coordination of benefits (COB) data model outlined in the implementation guides. This means the provider originates the transaction and sends claim or encounter information to the CA. The CA will reformat the transaction and send it to MDCH. The CA has ultimate responsibility for sending 837 encounter information on to MDCH. The 837 provider-to-payer-to-payer COB model promotes the handling of coordination of benefits data. It is important to note that if there is another payer identified as primary, such as Medicare or another Commercial carrier, the provider must send the claim to the primary payer for adjudication prior to sending the claim or encounter information on to the CA. The CA must include the primary payer's adjudication information, as well as their own, in the 837 transaction being sent to MDCH. Implementation guides contain notes on each COB-related data element specifying when it is used. This manual will provide guidelines for those data elements identified as most important to MDCH.

Depending on the type of service provided, encounter transactions may need to be submitted using either the Institutional (X096), Dental (X097) or Professional (X098) Industry Identifier of the 837 Encounter Transaction. As a general rule, if the service provided is billed using the Health Care Financing Administration Common Procedural Coding System (HCPCS) codes, including the American Medical Association's (AMA's) Current Procedural Terminology (CPT) codes, it is billed as an 837 professional claim and reported as an 837 professional encounter. If billing rules require the service to be billed using

a National Uniform Billing Committee (NUBC) Revenue Code, or Revenue Code and HCPCS code, the format for the claim and encounter would be the 837 institutional. When billing for the service requires the American Dental Association's (ADA's) Code on Dental Procedure and Nomenclature, contained in the Current Dental Terminology (CDT-3) user guide, the claim and encounter would be the 837 dental transaction.

Implementation instructions are contained in detailed manuals known as implementation guides. The implementation guides provide specific instructions on how each loop, segment, and data element in the specified transaction sets should be used. These guides are available from the Washington Publishing Company. You can order these guides by contacting:

Washington Publishing Company
PMB 161
5284 Randolph Road
Rockville, MD 20852-2116
Phone (301) 949-9740

The guides may also be ordered on line or downloaded at no charge at http://www.wpc-edi.com/hipaa/HIPAA_40.asp. Note that the guides are quite large and could take some time to download.

The implementation guides are the primary source of information on how to implement the 837 encounter, provider-to-payer-to-payer COB data model.

MDCH has published Data Clarifications for the 837 Institutional, Professional and Dental Encounter, Version 4010. These documents are companion documents to the implementation guides; they supplement and clarify parameters when the implementation guide provides options or "situations". They also provide identifiers to be used when a national standard has not been adopted.

The information in the Data Clarification documents will be helpful to the CAs as they develop outbound 837 encounter transactions. These clarification documents can be found at http://www.michigan.gov/mdch. Once you have reached the web site, click Providers, Information for Medicaid Providers, HIPAA for Medicaid Providers, Data Clarification Documents. There are Data Clarifications for 837 Claims and for 837 Encounters available. The CAs should make certain they are using the Data Clarifications for encounters when developing their 837 encounter transaction. In addition, CAs should check the web site regularly for updates or changes to these documents.

2.3 Data Submission Process

Encounter data submitted in the 837 format will be submitted through the MDCH Data Exchange Gateway (DEG) on a monthly basis, at a minimum. CAs may submit encounter data more frequently if necessary.

In order to communicate electronically with MDCH, the CA must first obtain an Identification Number and password from the MDCH Automated Billing Unit. For general instructions on how to obtain that Identification Number and password, please refer to the MDCH Electronic Submission Manual, which can be found on the web at www.michigan.gov/mdch. Once you have reached the web site, click Providers, Information for Medicaid Providers, Michigan Medicaid Uniform Billing Project, Electronic Claims Submission Information.

Before an encounter file can be submitted to MDCH for processing, the file must be prepared. Instructions can be found in the MDCH Electronic Submission Manual, Section 4, Preparing Electronic Claim Files. It is important to note that all ANSI X12 files have header and trailer data built into them.

Professional, institutional and dental encounters may be combined in one file, or may be transmitted in separate files. Each file must include an Interchange Envelope, containing various ISA elements as specified in the implementation guide. The encounter file must specify **ENCOUNTER** in the Interchange Receiver ID (ISA08) element and **P** in the Usage Indicator (ISA15) element.

The Interchange Envelope may contain one or more Functional Groups. Each Functional Group will specify whether that Functional Group contains Institutional, Dental or Professional encounter transactions. In the Application Receiver's Code (GS03) element of each Functional Group, you must specify **ENCOUNTER**. The Version/Release/Industry Identifier Code (GS08) element of each Functional Group must contain **004010X096**, **004010X097**, or **004010X098**, indicating whether that group contains institutional, dental, or professional encounter transactions, respectively.

To submit the 837 v 4010 encounter file, log onto the DEG (Data Exchange Gateway), using the instructions outlined in the MDCH Electronic Submission Manual, Section 5, Using the Data Exchange Gateway.

When you send an Encounter file to the DEG, take the following steps.

1. Type:

   Put<space> <volume>\<directory>\<file> <space> <file number>@<location>
   For example, **put<space>c:\dos\4951@dchedi**, where **c** is the hard drive, **DOS** is the directory, **4951** is the file for the CA encounter, followed by a space, the **@** sign, and a location of **dchedi** (**dch** indicates the Department of Community Health, and **edi** indicates the American National Standards Institute X12 837 transaction format). The submitter would type:

   PUT C:\DOS\4951 4951@DCHEDI

2. Once the file is transferred to **dchedi**, translation begins immediately and an ANSI X12 997 Functional Acknowledgement is produced and moved to the sender's mailbox.

3. Enter the **dir** command to see the ANSI X12 997 Functional Acknowledgement with the name of the file sent.

4. Download the ANSI X12 997 Functional Acknowledgement by entering a get command, being careful to change the file name for the destination system so the file sent is not written over. For example, adding an "a" to the file name would indicate that it has been acknowledged.

After you have issued the PUT command and the file has been transferred, you can do a "DIR" (Directory Command) to see if the 4951 file exists in your Mailbox.

CAs should copy transferred files immediately as a back up for their site. It is the agent's responsibility to retain back-up files until the party at the final destination has verified and backed up the files. Should the file not be received in its entirety, it may have to be resent using the back up.

As mentioned, after the file has been received by MDCH, a 997 Functional Acknowledgement transaction will be generated and submitted to the CA's mailbox. It can be retrieved via the DEG. The Functional Acknowledgment contains segments that can identify the acceptance or rejection of the functional group, transaction sets or segments. It is important that the CA retrieve the 997 acknowledgements to determine if MDCH has received the ASC X12 837 transaction sets, and identify transmissions that have not been acknowledged.

2.4 Implementation Timeline

For all services incurred on or after October 1, 2002, the CA is required to send data monthly on post-adjudicated encounters in the new 837 format. Encounter data is required to be submitted by the last day of the month following the month in which it was adjudicated.

To assist in the transition MDCH will allow encounters for claims adjudicated in the months of October, November, and December 2002 and January 2003 to be submitted by March 3, 2003. Submission is due by 5:00 p.m. on the last day of the month following the month it was adjudicated. Services that have been provided but for some reason are still in the adjudication process will be reported using a year-end reconciliation process. The year-end reconciliation process is described in Section 2.5 below.

MDCH will be retiring its current proprietary encounter format November 2002. CAs must have all FY2002 data or updates submitted by November 15, 2002.

2.5 Year-End Reconciliation Process

Substance abuse encounters are required to be submitted by the last day of the month following the month it was adjudicated. Any encounter that has not been reported by the end of the fiscal year because the adjudication process is incomplete, must be reconciled within 90 days of the last month of the fiscal year. That means the CA will have 90 days following the end of the fiscal year to submit the encounter data. For example, if the date of service is January 20, 2003 and by September 30, 2003 still has not been adjudicated by the primary payer, the CA is required to submit an encounter reporting the services provided with $0 reported in the approved and paid amount fields by December 31, 2003. The claim or service line adjudication date, whichever is applicable to the encounter being submitted, should be reported with a date value of 99999999. This will allow the transaction to be processed without indicating adjudication has taken place.

The CA will then be required to submit a replacement encounter by the last day of the month following the month it was adjudicated, once it is finally adjudicated.

2.6 Reporting Requirements

MDCH requires CAs to report encounters for all consumers whose services are paid for in whole or in part with MDCH administered funds. CAs **are not required** to submit encounters in the following instances:

- children's waiver services that are billed fee-for-service directly to Michigan Medicaid, (QI data files are still required to be submitted), and,
- room and board reimbursed through State Disability Assistance (SDA) funds.

In situations where the client has dual eligibility (i.e., Medicare/Medicaid), the CA is required to submit encounter data for the services provided.

2.7 Encounter Data Edits

To ensure the usefulness of the data submitted, the data must meet minimum thresholds of data quality. One of the most basic tests of data quality is editing. All data currently submitted to MDCH are subjected to an editing process. All 837 encounter data will also be subjected to an editing process. Appendix B, Encounter Error List, lists the 837 encounter edits that correspond to errors identified during the encounter data warehouse editing process.

Encounter data edits can have one of the following results:

1. The data pass all edits and is accepted into the data warehouse,
2. The data contain a minor error(s); an informational edit report is generated and the data is accepted into the data warehouse, or
3. The data contain a fatal error that results in its rejection.

Output from the edit process is an Error Return File that will be available to the CAs at their mailbox through the DEG. The file layout, including header and trailer records, can be found in Appendix C. This report is different than the 997 Functional Acknowledgment discussed earlier. The report will advise of the status of the records submitted in a particular file. If the records result in any errors being identified in the editing process, the report will specify the records that contain errors and the nature of the errors.

When retrieving the Error Return File from the DEG, you must use the "get" command. Once your logon has been accepted, the prompt **ftp>** appears, type **dir** to select the directory of files available. From the list of files that may be shown, look at the column labeled **APPL**, these are the files ready to be retrieved. The 837 Encounter Error Return File APPL ID is 4950. Therefore, you would type:

get 4950 c:\download\4950

This will move the oldest 4950 file to the sender's PC. The file will downloaded to the C drive, in the "download" directory, to file 4950.

All Error Return Files will reference the data submission number. It is critical that the CA track their data submission number.

2.8 Rejection Criteria

MDCH will reject encounters that fail to meet specified edit criteria. The following outlines situations that will result in the rejection of an entire batch, an individual encounter, or a specific service line.

A. Batch

There are minimal structural requirements that must be met to allow an entire batch to be properly read and interpreted. If a transmitted batch fails to meet any of the following criteria, the entire batch will be rejected:

1. Submitter Identifier (Loop 1000A, NM109) is missing or invalid
2. Submission Number (HDR, BHT03) is missing

3. Submission Number (HDR, BHT03) is not alphanumeric
4. Submission Number (HDR, BHT03) has been used on a previous batch
5. Transaction Type Code (HDR, BHT06) is not "RP", encounters
6. Transmission Type Code (HDR, REF02) is missing or invalid

MDCH will not reject an entire batch based on the contents of individual records within the file.

B. Encounter

Rejections below the batch level may occur for an entire encounter. An encounter is defined as all of the services incurred under the same claim/encounter identifier assigned by the provider or the CA. The following situations will result in rejection of the encounter, including all of the services that are part of the encounter:

1. The data in any of the following fields is missing or invalid:
    a. Other Payer Primary Identifier (Loop 2330B, NM109)
    b. Submitter Primary Identifier (Loop 1000A, NM109) is not valid for the Other Payer Primary Identifier (Loop 2330B, NM109)
    c. Other Payer Secondary Identifier – Encounter Reference Number (Loop 2330B, REF02)
    d. Service Line Number - Counter (Loop 2400, LX01)
    e. Claim Frequency Type Code - Original, Void, Replacement (Loop 2300, CLM05-3)
    f. Subscriber Primary Identifier (Loop 2010BA, NM109)
    g. Admission Date (Institutional transactions only) (Loop 2300, DTP03)
    h. Principal Diagnosis Code (Institutional transactions only) (Loop 2300, HI01-2)

2. The encounter is a duplicate of a previously submitted encounter.

3. The encounter is a void or replacement of an encounter that does not exist in the data warehouse.

C. Service Line

It is possible MDCH will reject only a service line from a submitted encounter. The reason for this is to keep the data warehouse as complete as possible while awaiting corrected encounters. If an edit fails a service line, only the failing service line will be rejected, all other data will be stored on the warehouse. If there is only one service line on an encounter and that service line is rejected, the entire encounter will be rejected. The following are examples of situations in which a service line will be rejected for missing or invalid values.

1. Service Date (Loop 2400, DTP03)
2. The first Diagnosis Code Pointer "points" to an invalid diagnosis code (Professional Loop 2400, SV107-1)
3. Procedure Code (Professional Loop 2400, SV101-2, Dental Loop 2400, SV301-2, and those Institutional [Loop 2400, SV202-2] transactions where services require both a Revenue Code and a HCPCS code)
4. Revenue Code (Institutional Loop 2400, SV201)
5. Units (Professional Loop 2400, SV104, Dental Loop 2400, SV306, Institutional Loop 2400, SV205)

2.9 Correction Process

Resubmission is the process the CA uses when the encounter has not made it through the translator or processing and there is subsequently no data stored in the data warehouse. The CA will need to resubmit when a 997 Functional Acknowledgement is received indicating the submission was not accepted or if the Error Return File contains messages that result in an action of "Reject Batch" or "Reject Encounter", indicating the submission could not be processed.

Replacement is the process the CA uses when the encounter has made it through the translator and processing system and is stored in the data warehouse, but for some reason needs to have corrections made to the data originally submitted. The CA will need to replace an encounter if the Error Return File contains a message that results in an action of "Reject Line", if there has been a change in the number of units originally reported, if there has been a change in the monetary amounts originally reported, if the claim has been adjudicated since the encounter was reported using the year-end reconciliation process, and if there has been a change in the client's eligibility changing the funding source reported in the original encounter (i.e., General Fund to Medicaid).

Batches, encounters or service lines that were rejected by the system must be corrected and resubmitted within 30 days of the date the Error Return File was created. Refer to Appendix C, 837 Encounter Error Return File, for the "Creation Date" element reported in the Error Return File header and trailer records.

When MDCH **rejects an entire batch**, the CA must make the necessary corrections and **resubmit the batch**. The individual transactions in the resubmitted file must have the same Claim Frequency Code (Loop 2300, CLM05-3) designation (i.e., original, void, or replacement) as what was reported on the rejected file. These should not be designated as replacement encounters. Since the contents of a rejected batch are not retained in the data warehouse, there is no record to replace in the warehouse.

When MDCH **rejects the encounter**, the CA must correct the identified error(s) and **resubmit the encounter**. As with a rejected batch, a rejected encounter is not stored in the data warehouse, so the corrected encounter will be submitted with the same Claim Frequency Code designation as was coded on the first submission. If the rejected encounter was an original encounter, the "corrected" encounter should also be an original encounter.

When MDCH **rejects a service line**, the CA must correct the identified error(s) and **replace the entire encounter, including those service lines that were accepted by the data warehouse in the original submission**. The MDCH encounter data warehouse processing system will replace in the warehouse the entire original encounter with the data submitted on the replacement encounter. The Claim Frequency Type Code is a "claim" level code, which means the entire claim/encounter is designated as either original, void, or replacement; this designation cannot be applied to an individual service line.

If MDCH rejects a service line and there are multiple service lines on the encounter, the service lines that pass the edits will be retained in the data warehouse. While MDCH may reject only one service line reported on an encounter that contains multiple service lines, the CA may not correct a single service line on an 837 encounter transaction. The CA has two options:

1. The CA may replace the entire encounter once the errors have been corrected. The entire encounter (the service line that originally contained errors and all associated services) will be completely replaced in the data warehouse. The following information must be included within the 837 encounter:

a. The Claim Frequency Type Code (Loop 2300, CLM05-3) on the replacement encounter must now be designated as replacement.
b. The Replacement Claim Number (Loop 2300 REF02 and Loop 2330B REF02) must be the same as the claim number on the original claim.

Since service line numbers within the 837 encounter must begin at "1" and increment by "1", any attempt to correct a single line in a previously submitted and accepted encounter that contained multiple services would result in the replacement encounter deleting all of the previously accepted services.

2. The CA may leave the original encounter minus the rejected service(s) "as is" in the warehouse and create a new encounter reporting only the corrected service line(s). The new encounter must report a different claim number and should report a Claim Frequency Type Code of "Original". CAs should NOT use this option for correcting a service that is already in the data warehouse, as it would result in the service being duplicated.

If the CA must replace or void a service that has been accepted into the data warehouse, it must do so by replacing or voiding the entire encounter on which the service originally appeared. The claim number for the replacement or void encounter must be the same as the original claim number.

An encounter that was submitted by the CA can only be voided if the CA identifies that the client identified in the original encounter is not correct or if the CA identifies that the CA identified as the "Other Payer" in the encounter is not correct. The CA would never void an encounter to replace an encounter. To replace an encounter follow the steps outlined above. To void an encounter, the CA would change the encounter designation to void (Loop 2300, CLM05-3 value of "8") and the Original Reference Number must be used (Loop 2300, REF02 and 2330B, REF02). When an encounter is voided, the CA must submit a new "original" encounter to report the service requiring reporting.

2.10 837 Encounter Data Elements

The 837 transaction contains a number of required and situational data elements. It is MDCH's intention to use many of these data elements to enhance the information available in the data warehouse. This section outlines many of the data elements that are of particular interest to MDCH, those that may be used in the processing of the 837 encounters, and those that have resulted in many questions from CAs.

These supplemental instructions do not address all of the data elements in the 837 transaction. Note that implementation of the 837 encounter must include all required and applicable situational data elements identified in the implementation guide, not just those mentioned in this section.

2.10.1 Transaction Type Code (HDR, BHT06)

All 837 transactions require the coding of a claim or encounter indicator. Transaction Type Code, which performs this function, appears in the Header Table portion of the transaction set. Specifically the BHT, or Beginning Hierarchical Transaction, segment must include data element BHT06. CAs must code this data element to a value of "RP" for all encounter data reporting. The value of "RP" should be reported whether the CA reimburses the provider on a fee-for-service, per diem, other payment basis.

2.10.2 Insured Group Name (Loop 2000B, SBR04)

To report that the client is enrolled in the MIChild program, the CA must report the value "MICHILD" in SBR04, Insured Group Name.

2.10.3 Subscriber Primary Identifier (Loop2010BA, NM109)

CAs are reporting on a number of clients, many enrolled in various Medicaid programs, many not enrolled in Medicaid at all but whose services are paid through a variety of funding sources, and some enrolled in MIChild. Clients are identified in these programs through the use of different unique identifiers. Since there is no national or MDCH standard subscriber primary identifier, CAs should follow these guidelines:

- If the client is enrolled in Medicaid, report their 8-digit Medicaid ID number
- If the client is enrolled in MIChild, report their 8-character Client Identification Number (CIN) assigned by the enrollment broker
- For persons not enrolled in Medicaid or MIChild, report their 9-digit Social Security Number
- Use the CA's unique identifier (CA Client Identifier) **only** when the person is not enrolled in Medicaid or MIChild, and the Social Security Number is not known. The CA Client Identifier **must** be 11-characters. It may be alphanumeric. If necessary, right justify and zero fill to the left to create an 11-character value.

2.10.4 Contract Information (Loop 2300, Segment CN1 and Loop 2400, Segment CN1)

When the contract arrangement between the CA and their providers is anything other than fee-for-service, MDCH recommends that this situational segment be reported to help explain monetary amounts and adjudication information provided within the 837 transaction. This information is optional at this time, however, if the CA chooses to report contract information the following guidelines should be used.

2.10.4.1 Contract Type Code (Loop 2300, CN101 and Loop 2400, CN101)

Report one of the values as indicated in the standard code list provided. MDCH anticipates that many of the contract type codes reported may fall into the category of "Other", value "09".

2.10.4.2 Contract Amount Code (Loop 2300, CN102 and Loop 2400, CN102)

The CA should report the contract amount as indicated by the instructions in the implementation guide. Report the contract amount for the Contract Type indicated in Loop 2300, CN101 or Loop 2400, CN101. If the Contract Type Code is "Per Diem", the per diem rate would be reported in this element.

2.10.4.3 Contract Percent Code (Loop 2300, CN103 and Loop 2400, CN103)

The CA should report a percent in this element only if the Contract Type Code reported in Loop 2300, CN101 or Loop 2400, CN101 is "Percent". The value represents the contract percentage or charge percent.

2.10.5 Principal Diagnosis (Loop 2300, HI01)

The 837 transaction sets allow a large number of diagnosis codes to be reported – over 14 on institutional encounters and eight on professional encounters. MDCH will collect up to 14 diagnosis codes for institutional encounters (the primary diagnosis, the admitting diagnosis, and twelve additional diagnosis codes) and up to eight diagnosis codes for professional encounters. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is the standard code set CAs must use for reporting diagnosis codes. MDCH expects that all encounters will have a diagnosis reported.

The diagnosis represents the reason for the encounter. Therefore it could be signs, symptoms, diagnosis if available, or other reason for the encounter. CAs should not ignore the V-series codes identified by ICD-9-CM. These codes include diagnoses that relate to encounters for various reasons, including administrative.

The ICD-9-CM Diagnosis Code for Other Unknown and Unspecified Cause (799.9) may be used **only** in the following situations:

- The client has a relationship with a client receiving substance abuse services and is receiving services for co-dependency.

2.10.6 Type of Bill (Institutional Loop 2300, CLM05)

For institutional services, Type of Bill is a standard field that has been required on the UB-92 form and that provides several different pieces of information. The first digit of this data element identifies the type of facility (hospital, office, home, etc.). The second digit is referred to as the bill classification and conveys information on the place of service. The third digit is the frequency code and identifies the type of billing (e.g., original, interim, final, adjustment, void). MDCH will be using the components of Type of Bill to identify Record Type (original, void, replacement) and institutional place of service codes.

2.10.7 Facility Type Code (Loop 2300, CLM05-1 and Loop 2400 SV105 Professional and Dental)

The data element identifies the type of facility where services were performed. CAs must refer to the standard code sets from the National Electronic Media Claims National Standard Format available from http://cms.hhs.gov/states/poshome.asp.

2.10.8 Diagnosis Code Pointers (Professional Loop 2400, SV107-1, SV107-2, SV107-3, SV107-4)

Diagnosis codes for both institutional and professional transactions are provided at the claim level in the 837 transactions. For professional services, the 2400 service loop provides segments that contain diagnosis code pointers. These pointer data elements contain a value of one through eight. These values "point to" the diagnoses coded at the claim level that most closely correspond to each service line. Each service line can have up to four diagnosis pointers, or four separate diagnosis codes for each service. Each service may point to a different set of four diagnosis codes.

2.10.9 Rendering Provider Primary Identifier (Loop 2310B, NM109)

With the implementation of the 837 transaction, CAs will need to report at least two identifiers for servicing (or rendering) providers. The servicing (or rendering) provider is the person or entity that actually provided the service. For rendering providers, the NM1 segment is required and will be used to report either the Employer Identification Number (EIN) or Social Security Number (SSN) of the provider. Note that this will be the case until the National Provider Identifier or NPI is adopted and all NM1 provider segments will then require the use of the NPI.

2.10.10 Rendering Provider Secondary Identifier (Professional Loop 2310B, REF02)

Secondary identifiers are carried in the REF segment and MDCH requires CAs to report either the Medicaid ID or State License Number for all in-state providers. The 837 institutional encounter requires the identification of the service facility where services were provided (Loop 2310E, REF02). The nine-character Payer Identification number should never be used to report the rendering provider secondary identifier.

2.10.11 Other Subscriber Information (Loop 2320) Segment SBR

Loop 2320, Segment SBR reports information primarily about the Other Subscriber. This loop is required when there are known other payers potentially responsible for payment of the services reported. This loop repeats. MDCH will always be the receiver identified in Loop 1000B, therefore, none of the information reported here is specific to MDCH. The CA is an "other payer" and information specific to their responsibility and the subscriber's relationship to them would be reported in the SBR segment. Any other commercial payer or Medicare would be reported in an iteration of this loop as well.

2.10.12 Payer Responsibility Sequence Number Code (Loop 2320, SBR01)

This element identifies the level of financial responsibility all other payers have with respect to the services reported. Appropriate values to report are "P" for primary, "S" for secondary, and "T" for tertiary. The transaction must always have one payer identified as primary. If there are multiple payers, the level of responsibility for each must be determined. If the consumer has Medicare **or** a commercial

carrier with financial responsibility, the commercial carrier **or** Medicare would be the primary payer and therefore "P" would be reported for them. In this example, the CA would be reported as the secondary payer, "S". If there is Medicare **and** a commercial payer, the commercial carrier would be identified as primary, "P", and Medicare secondary, "S". The CA would then be reported with a value of "T", tertiary. Tertiary can be reported multiple times if needed.

2.10.13 Other Insured Identifier (Loop 2330A Other Subscriber Name – NM109 Other Insured Identifier)

All substance abuse encounters will require the reporting of the CA Client Identifier in Loop 2330A, NM109. This element is intended to report the unique member number assigned by the plan or other payer (CA). The CA Client Identifier **must** be reported here even when it was used as the subscriber primary identifier in Loop 2010BA, NM109. The CA Client Identifier must be 11-characters in length. Right justify and zero fill to the left if required to create an 11-character CA Client Identifier.

2.10.14 Other Payer Primary Identifier (Loop 2330B Other Payer Name – NM109 Other Payer Primary Identifier)

The contract between MDCH and the CAs for capitated substance abuse services places responsibility on the CA for the management of client services and payment for services rendered by contracted providers. The CA is reported as an Other Payer (Loop 2330B). A Payer Identification (PI) number is required in Loop 2330B, NM109 of the 837 to identify the Other Payer(s). MDCH will enroll CAs as payers. They will receive a nine-character number (for example, 17XXXXXXX) that identifies them as an MDCH health plan. This number will be required to be reported as their Payer ID until such time as the national standard Plan ID is implemented. MDCH will use this identifier to identify the CA within the encounter transaction. This number is also used to link the 837 Encounter with the client's corresponding QI data file. This number is different than the Provider Identifier used to identify the direct care provider.

To report other commercial payers, the CA should use the carrier code assigned by MDCH. The carrier codes can be found in a listing posted on the MDCH website, www.michigan.gov/mdch. Click Providers, Information for Medicaid Providers, then Third Party Liability. Medicare does not have an MDCH assigned carrier code. When reporting Medicare as an Other Payer, the following numbers should be used to report the Other Payer Primary Identifier:

- Medicare Part A (United Government Services), use "00452"
- Medicare Part B (Wisconsin Physician Services), use "00953"

2.10.15 Procedure Code (Professional Loop 2400, SV101-2, Dental Loop 2400, SV301-2, and Institutional Loop 2400, SV201 for Revenue Code and SV202-2 for Service Line)

MDCH has developed a list of procedure and revenue codes to be used when submitting 837 encounter and claims data for substance abuse services. The Centers for Medicare and Medicaid Services (CMS) has not yet approved all the codes for substance abuse that the states have requested. The requested codes will not be approved and available for use in time for implementation of the ASC X12N 837 version 4010 encounter format. Therefore the code crosswalk developed by MDCH will be used for reporting revenue codes and procedure codes on 837 encounters and claims until otherwise notified. The code crosswalk for substance abuse services is posted on the MDCH website which should be checked regularly for updates. The code crosswalk can be found at the following address:

http://www.michigan.gov/documents/CA-Crosswalk100302jk1_45786_7.doc

2.10.16 Financial/Adjudication Data Elements

The provider-to-payer-to-payer COB data model of the 837 is being used and will provide MDCH with expanded financial information on encounter records. The loops in the 837 HIPAA implementations that are used to convey information regarding adjudication are the 2320 (Other Subscriber Information) and 2430 (Service Line Adjudication Information). **Reporting of financial data is voluntary through September 2003. If CAs choose to report financial data for FY03 encounters, the following guidelines should be followed.**

The financial, or adjudication fields that MDCH requests the CAs to report include:

- Submitted Line Item Charge Amount (Provider Billed Amount)
- Approved Amount (Allowable Amount)
- Paid Amount
- Adjustment Amounts
- Adjustment Group and Reason Codes

2.10.16.1 Submitted Line Item Charge Amount (Professional Loop 2400, SV102, Institutional Loop 2400, SV203)

MDCH expects CAs to report the provider submitted charge amount or billed amount. This charge generally represents the provider's usual and customary amount for the service. There have been no situations identified where substance abuse services would not have a charge. Therefore, the amount coded in the Submitted Charge Amount data element should not be "0" (zero).

Institutional encounters also accommodate reporting total submitted charges (COB Total Submitted Charges) within Loop 2320, AMT02.

2.10.16.2 COB Approved (Allowed) Amount (Professional Loop 2320, AMT02 and Loop 2400, AMT02, Institutional Loop 2320, AMT02 [COB Total Allowed Amount])

CAs should report their fee schedule amount, or what they would have paid for the service (maximum allowable amount), whether or not the service was covered with the provider on a per diem, case rate, prepaid or other payment basis. If the CA never covers the specific service reported, the Approved Amount may be "0" (zero).

2.10.16.3 COB Payer Paid Amount (Loop 2320, AMT02 and Loop 2430, SVD02)

If the CA paid the provider for the service, the Paid Amount should reflect the amount paid. If the service was not covered by the CA, or was covered under a contract payment methodology such as prepaid or per diem, "0" (zero dollars) may be an appropriate Paid Amount.

2.10.16.4 Other Payer Adjustment Amount (Loop 2320, CAS03, CAS06…CAS18 and Loop 2430, CAS03, CAS06…CAS18)

If the Paid Amount reflects any adjustment to the billed amounts, the adjustment amount, as well as adjustment reasons must be reported.

2.10.16.5 Other Payer Adjustment Group Code (Loop 2320, CAS01 and Loop 2430, CAS01)

This data element identifies the general category of payment adjusted. The CA must use the values identified in the implementation guide. Code values include, "CO" for contractual obligation, "OA" for Other Adjustments, and "PR" for patient responsibility.

2.10.16.6 Other Payer Adjustment Reason Code (Loop 2320, CAS02, CAS05…CAS17 and Loop 2430, CAS02, CAS05…CAS17)

This element is required to report the detailed reason for any adjustment to the submitted line item charge amount. CAs must use the standard Claim Adjustment Reason Codes available at www.wpc-edi.com.

Example A: CA "A" pays a contracted provider on a fee-for-service basis for all services. The CA uses a fee schedule to determine its approved (allowed) amount. John Doe is seen for Individual Therapy, adult or child, 45-50 minutes and the provider submits a claim to CA "A". CA "A" adjudicates the claim and then reformats and sends an 837 encounter to MDCH.

Submitted Charge	Approved Amount	Paid Amount	Adjustment Reason	Adjustment Amount
$100	$55	$55	42 - charges exceed our fee-schedule or maximum allowable amount	$45

Example B: CA "B" has a per diem contract arrangement with a local facility to provide intensive outpatient (IOP) services. The per diem rate is $100 per day. John Doe receives 13 days of IOP services. There is no other payer. CA "B" submits the encounter to MDCH.

Submitted Charge	Approved / Allowed Amount	Paid Amount	Adjustment Reason	Adjustment Amount
$2500	$1300	$0	A2 – contract adjustment	$2500

Any time the charge amount does not equal the paid amount, the CA must report the adjustment amount and the adjustment reason.

When reporting financial data CAs should heed the balancing requirements outlined in the Implementation Guides.

3.0 Quality Improvement (QI) Data Reporting

3.1 QI Data Reporting Format

MDCH collects and reports Quality Improvement (QI) data for every consumer whose services are paid for in whole or in part with MDCH administered funds. QI data is required to be reported monthly for each consumer who received service during the month and for whom an encounter data record is also being submitted.

QI data submitted by the CAs will be reported in three separate files:

1. Treatment Admission Records,
2. Treatment Discharge Records, and
3. Screening, Assessment, Referral, and Follow-up (SARF) Records.

Substance abuse QI data is submitted in an MDCH proprietary flat file format. Appendix D defines the flat file layout for the Admission, Discharge and SARF record files, including the header and trailer records.

3.2 QI Data Submission Process

QI data submitted in the MDCH proprietary format will be submitted through the MDCH Data Exchange Gateway (DEG) on a monthly basis. The 837 encounter data files and the QI data files will be linked to accommodate the various MDCH reporting and program management requirements. The 837 encounter file and the three separate types of QI files result in the following subscriber dependencies:

- A SARF and/or Admission record is required to be submitted and posted to the data warehouse before an 837 Encounter can be processed.
- An Admission record is required before a Discharge record can be processed.

Failure to submit a SARF and/or Admission record prior to the 837 Encounter record will result in an 837 encounter rejection due to the dependency of the encounter on the QI record files. For FFS children's waiver claims, there is no dependency on the QI record files, therefore it is not necessary to ensure that a SARF and/or Admission record are submitted prior to the claim.

As with the 837 encounter, to communicate electronically with MDCH, the CA must first obtain an Identification Number and password from the MDCH Automated Billing Unit. For general instructions on how to obtain that Identification Number and password, please refer to the MDCH Electronic Submission Manual, which can be found on the web at www.michigan.gov/mdch. Once you have reached the web site, click Providers, Information for Medicaid Providers, Michigan Medicaid Uniform Billing Project, Electronic Claims Submission Information.

Before a QI file can be submitted to MDCH for processing, the file must be prepared. Instructions can be found in the MDCH Electronic Submission Manual, Section 4, Preparing Electronic Claim Files. It is important to note that unlike the ANSI X12 files, the QI data files do not have header and trailer data built into them. Header and trailer files will need to be built into the QI data files. Refer to Appendix D of this manual for QI data file header and trailer layouts.

To submit a QI data file, log onto the DEG (Data Exchange Gateway), using the instructions outlined in the MDCH Electronic Submission Manual, Section 5, Using the Data Exchange Gateway.

When you send a QI file to the DEG, take the following steps.

> Type:
>
> Put<space> <volume>\<directory>\<file> <space> <file number>@<location>
>
> For example, **put<space>c:\dos\4825@dchbull**, where **c** is the hard drive, **DOS** is the directory, **4825** is the file for the CA QI SARF data file, followed by a space, the **@** sign, and a location of **dchbull** (**dch** indicates the Department of Community Health, and **bull** indicates an MDCH proprietary transaction format). The submitter would type:
>
> PUT C:\DOS\4825 4825@DCHBULL

The above instructions provide an example of sending a SARF Record using the file number of 4825. To send an Admission Record the file number to use is 4823. To send a Discharge Record, use the file number of 4824.

CAs should copy transferred files immediately as a back up for their site. It is the agent's responsibility to retain back-up files until the party at the final destination has verified and backed up the files. Should the file not be received in its entirety, it may have to be resent using the back up.

3.3 Implementation Timeline

For all services incurred on or after October 1, 2002, the CA is required to send monthly QI data files. To assist in the transition MDCH will allow QI data for the months of October, November, December 2002 and January 2003 to be submitted by March 3, 2003. Submission is due by 5:00 p.m. on the last day of the month following the date of service.

CAs must have all FY2002 data or updates submitted by November 15, 2002 to allow for the transition to the FY2003 requirements

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3.4 Reporting Requirements

As with 837 Encounter data, CAs are required to submit QI data monthly for all consumers whose services are paid for in whole or in part with MDCH administered funds. Refer to Appendix A for Data Collection/Recording and Reporting Requirements – Effective 10/1/2002. CAs are required to submit QI data files for consumers whose children's waiver services have been billed fee-for-service directly to Michigan Medicaid. The QI data files will be matched to the fee-for-service claims data stored on the data warehouse. FFS claims do not depend on the QI files and will not be rejected if the claim is submitted prior to the submission of the QI files.

3.5 QI Data Edits

To ensure the usefulness of the data submitted, the data must meet minimum thresholds of data quality. Once the QI data is submitted through the DEG it is edited and stored on the data warehouse. The editing processes include checking data conditions to determine acceptance or rejection of the QI data. QI data edits can have one of the following results:

1. The data pass all edits and is accepted into the data warehouse,
2. The data contain errors identified in the Business Rule Considerations and the input record is rejected, and
3. The data contain errors in the input file header or trailer records causing the batch to be rejected.

Appendix E contains a list of all the substance abuse SARF Data Element Edits, Admission Data Element Edits and Discharge Data Element Edits listed in the order of the input file format. All errors reported in these lists will cause the record to be rejected.

Output from the QI edit process is an Error Return File that will be available to the CAs at their mailbox through the DEG. The report will advise of the status of the records submitted in a particular file. If the records result in any errors being identified in the editing process, the report will specify the records that contain errors and the nature of the errors. Appendix F, Substance Abuse QI Error Return File, outlines the layout of the QI Error Return File, including header and trailer. An Error Return File is produced for each submitter. The file contains the errors produced from the substance abuse QI data element edits.

When retrieving the Error Return File from the DEG you must use the "get" command. Once your logon has been accepted, the prompt **ftp>** appears, type **dir** to select the directory of files available. From the list of files that may be shown, look at the column labeled **APPL**, these are the files ready to be retrieved. The Error Return File APPL ID is 4827. Therefore, you would type:

get 4827 c:\download\4827

This will move the oldest 4827 file to the sender's PC. The file will downloaded to the C drive, in the "download" directory, to file 4827.

All Error Return Files will reference the data submission number. It is critical that the CA track their data submission number.

3.6 Correction Process

Resubmission is the process the CA uses when the QI data file has not made it through processing and there is subsequently no data stored in the data warehouse. The CA will need to resubmit if the Error Return File contains messages indicating the batch or input record has been rejected.

Replacement is the process the CA uses when the QI data file has made it through processing and data is stored on the data warehouse, but for some reason the CA is required to make corrections to the QI data file.

QI data records rejected by the system must be corrected and resubmitted within 30 days of the date the Error Return File was created. Refer to Appendix F, Substance Abuse QI Error Return File, for the "Creation Date" element reported in the Error Return File header and trailer records.

There are primary key fields identified in the QI data files that are validated with each submission. For QI Data updates, or replacements, the files will be identified through these primary key fields and the original QI file will be replaced.

Appendices

Appendix A Data Requirements

DATA COLLECTION/RECORDING AND REPORTING REQUIREMENTS - Effective 10/1/2002

Overview of Reporting Requirements

The reporting of substance abuse services data by the CA as described in this material meets several purposes at MDCH including:

-Federal data reporting for the SAPT Block Grant application and progress report, as well as for the treatment episode data set (TEDS) reported to the federal Office of Applied Studies, SAMHSA.

-Managed Care Contract Management

-System Performance Improvement

-Statewide Planning

-CMS Reporting

-Actuarial activities

Special reports or development of additional reporting requirements beyond the initial data and reports required by the Department may be requested within the established parameters of the contract. The CA will likely maintain, for management and local decision-making, additional information to that specified in the reporting requirements.

Standards for collecting and reporting data continue to evolve. Where standards and data definitions exist, it is expected that each CA will meet those standards and use the definitions in order to assure uniform reporting across the state. Likewise, it is imperative that the CA employs quality control measures to check the integrity of the data before it is submitted to MDCH. Error reports generated by MDCH will be available to the submitting CA the day following a DEG submission. MDCH's expectation is that the records that receive error Ids will be corrected and resubmitted as soon as possible. The records in the error file are cumulative and will remain errors until they have been corrected.

Individual services recipient data received at MDCH are kept confidential and is always reported out in aggregate. Only a limited number of MDCH staff have access to the data that contains any possible individual client identifiers. (e.g. social security number, date of birth, diagnosis, etc.) All persons with such data access have signed assurances with MDCH indicating that they are knowledgeable about substance abuse services confidentiality regulations and agree to adhere to these and other departmental safeguards and protections for data.

Technical specifications, including file formats and record layouts for all required records, edit/error criteria, and explanatory materials on record submission types of "Add, Change, Delete" record submissions with associated records tagging requirements at the CA level to assure data synchronization with MDCH data records, are part of this package.

Reporting covered by these specifications includes the following:

-Treatment Admission Records (due monthly)

-Treatment Discharge Records (due monthly)

-Screening, Assessment, Referral and Follow up (SARF) Records (due monthly)

-HIPAA Compliant 837 4010 Encounter Records (due monthly)

-Performance Indicators Reports (due quarterly)

-Sentinel Events (due semi-annually)

Technical instructions and submission formats will be available in a Submitter's Manual to be issued in September of 2002.

Reporting requirements not reflected in this material, as they were issued earlier and remain in force as issued, include:

1) Prevention Minimum Data Set (monthly, computer file submissions)

2) Legislative Report data (due in early 2002)

3) Narrative Reports- see the AAPG for FY2002

A. Basis of Data Reporting

The basis for data reporting policies for Michigan substance abuse services includes:

1. Federal funding awarded to Michigan through the Substance Abuse Prevention and Treatment (SAPT) federal block grant to share in support of substance abuse treatment and prevention requires submission of proposed budgets and plans. Resources and plans must be reviewed and considered by the State in light of statewide needs for substance abuse services.

2. Public Act 368 of 1978, as amended, requires that the department develop:

   A comprehensive State plan through the use of federal, State, local, and private resources of adequate services and facilities for the prevention and control of substance abuse and diagnosis, treatment, and rehabilitation of individuals who are substance abusers.

   In addition, the department shall:

   Establish a statewide information system for the collection of statistics, management data, and other information required.

   Collect, analyze and disseminate data concerning substance abuse treatment and rehabilitation services and prevention services.

   Conduct and provide grant-in-aid funds to conduct research on the incidence, prevalence, causes, and treatment of substance abuse and disseminate this information to the public and to substance abuse services professionals.

3. Comprehensive planning requires statewide needs assessments to include identification of the extent and characteristics of both risks for development and current substance abuse problems for the citizens of Michigan.

B. Policies and Requirements Regarding Data

The following outlines the MDCH's policies and requirements for data collection/recording and reporting:

Treatment Data reporting will encompass Substance Abuse (SA) services provided to clients supported in whole or in part with state administered funds through MDCH/DCS/SA contracted funds and funds for SA services to Medicaid recipients included in CMHSP contracts. Prevention services data requirements are addressed in Minimum Data Set (MDS) instructions.

Definitions:

State administered funds = any state or federal funding provided by the MDCH/DCS/SA contract. Funds provided include federal SAPT Block Grant, state general funds, MIChild, and other categorical or special funds. Since funds provided under the contract include local match (fees and collections, local, and P.A. 2 as examples) data reporting requirements include those funds which are considered as "in-part" funding. Medicaid funds are covered under the MDCH/CMHSP contract as required reporting by CAs as part of their data reporting responsibilities.

Data = client admission and discharge records (for treatment services), client assessment records (for Screening, Assessment, Referral and Follow-up), and any services activity records (Monthly Client Activity Summary data) and back-up required to produce this information (e.g. billings from providers, services logs, etc.). Prevention services data are not addressed herein.

Services = Substance abuse treatment (residential, residential detox, intensive outpatient, outpatient, including pharmacological supports as part of above), substance abuse assessment (screening, assessment, referral and follow-up) provided by appropriately state licensed programs. Prevention services data are not addressed herein.

Supported in whole or in part = those services for which the CA pays, inclusive of copays with other sources of funds (e.g. first party, third party insurance, other funding sources).

Policy:

Reporting is required for all services paid in whole or in part with state administered funds regardless of the type of copay or shared funding arrangement made for the services. This includes both copay arrangements where public funds are applied from the starting date of admission to a service, as well as those where public funds are applied subsequent to the application of other funding or payments. In cases where subsequent payments are applicable, retroactive reporting of assessment, admission, and service activity records are required (back to the date when the service first began) in the current level of care/service category.

Data collected by the CA that is other than the above is not to be reported in any uploads or used in any other required reporting to MDCH. The CA is responsible for insuring that this other data is excluded from state reporting.

1. Data definitions, coding and instructions issued by MDCH apply as written. Where a conflict or difference exists between MDCH definitions and information developed by the CA or locally-contracted data system consultants, the MDCH definitions are to be used.

2. All data collected and recorded on assessment, admission and discharge forms shall be reported using the proper Michigan Department of Consumer and Industry Services (MDCIS) substance abuse services site license number. MDCIS license numbers are the only basis for recording and reporting data to MDCH at the program level.

Combined reporting of client data in data uploads from more than one license site number is not acceptable or allowable, regardless of how a CA funds a provider organization.

3. Failure to assure initial set up and maintenance of the proper site license number and CA code will result in data that will be treated as errors by MDCH. Any data submitted to MDCH with improper license numbers will be rejected in full. The necessary corrections and data resubmissions will be the sole responsibility of the CA in cooperation with the involved service providers.

4. Each admitted or served client shall have his/her Social Security Number (SSN) as the required individual client number.

   For recipients with an unknown SSN there must be a unique CA client identifier assigned and maintained. It can be up to 11 characters in length, all numeric. This same number is to be used to report data for all admissions and services for the individual within the CA. It is recommended that a method be established by the CA and funded programs to ensure that each individual is assigned the same identification number regardless of how many times he/she enters services in any program in the region, and that the client number be assigned to only one individual.

   "Dummy" client identifiers must not be used for any case of service provision.

5. Clients admitted to treatment services, by definition, have a current substance abuse problem of their own, or are a significant other/family member of someone with a substance abuse problem.

   MDCH expects client assessment and treatment admission forms to reflect accurate descriptions of clients seeking and entering treatment. This includes accurate reporting of days of substance use in the 30 days before entry to the program. If an individual has a personal substance abuse problem, it is unlikely that there has been no recent (within the last 30 days before coming into a program) use of some kind of substance unless the individual was incarcerated or otherwise could not physically obtain any illicit drugs or alcohol. This would not necessarily be the case for significant others/family members who may not use any substances themselves.

   Coding for significant other/family members who are admitted to treatment should be done using a code of "00" for primary drug abuse problem (within the Substance Use History data item layout), and the appropriate code describing their relationship to a substance abuser in the Codependent data item (Yes-No) or the "Other Factors" data item on the treatment admission records (either code 2=adult child, or 3=significant other).

   If a client has not used in the last 30 days and is not a current substance abuser, a service other than treatment may be warranted. Treatment services are intended for those with current substance abuse problems of their own, or of their family or significant other. Those with personal substance abuse problems will have one or more DSM-IV diagnosis codes assigned and also reported.

   Those persons entering treatment directly out of a controlled environment (jail or prison, or from a residential or inpatient service) may not have used a drug within the last 30 days. These situations should be carefully documented in client case files and include rationale as to why the client is being treated in the absence of current (past 30 days prior to admission date) substance abuse.

   If a client is "in denial" and states that he/she has not used within the last 30 days, this should be explored carefully during the initial admission visit. If there is no use, then a service other than admission to treatment may be appropriate.

6. Any changes or corrections made at the CA on forms or records submitted by the program must be made on the corresponding forms and appropriate records maintained by the program. Failure to maintain corresponding data at the CA and program levels will result in data audit exceptions on discovery of discrepancies during an MDCH on-site data audit/review. Each CA and its programs shall establish a process for making necessary edits and corrections to ensure identical records. The CA is responsible for making sure records at the state level are also corrected via submission of change records in data uploads.

7. Providers of residential and/or detoxification services must maintain a daily client census log that contains a listing of each individual client in treatment. This listing can be made in client name or using the client identification number. Census must be taken at approximately the same time each day, such as when residents are expected to be in bed. MDCH or the CA will review the daily client census logs in data auditing site visits.

   Providers of pharmacologic support services (either methadone or LAAM) must maintain a log that contains a listing of each client in treatment, and their daily dosages of these medications provided by the program. MDCH or the CA will review these logs in data auditing site visits.

8. Diagnosis coding on client data forms shall be consistent with the client's substance abuse treatment plan. If there is more than one substance abuse diagnosis determined, then the secondary diagnosis code should be reported accordingly. Diagnosis codes on the data records must be consistent with those listed on other client documentation (such as billing forms, etc.). Codes should be entered using only the proper DSM-IV definitions for substance abuse and other related problems that are being treated.

   The primary diagnosis should correspond to the primary substance of abuse reported at admission. The secondary diagnosis may or may not be consistent with the secondary substance of abuse if another diagnosis better reflects a more serious secondary problem than the secondary substance.
9. CAs are to provide training, manuals, and records/ forms to their funded services providers.

10. All data forms/records should be submitted by service provider organizations to the respective CA on a weekly or other regular schedule. This allows data to be relatively current and avoid data entry bottlenecks. Data records should be completely filled out and legible for editing and data entry by provider or by the CA. CAs have the right to return incomplete or erroneous forms to the program. It is the service program's responsibility to correct and resubmit data records in a timely fashion.

    CAs are to edit and correct as necessary all data records, and ensure that complete data entry occurs routinely as data flows into their offices and data systems. Data shall be as current as possible. All data from a particular month shall be entered into the CA's database by the end of the following month in preparation for uploading to MDCH.

11. The CA is responsible for generating each month's data upload to MDCH consistent with established protocols and procedures. Monthly and quarterly data uploads must be received by MDCH via the DEG no later than the last day of the following month.

12. The CA should not request MDCH to provide reimbursements for any program that does not submit complete and accurate data to the CA within the established reporting time lines. Late or incomplete data reporting by the provider and/or CA may result in the withholding and potential loss of funding from MDCH.

13. Treatment clients may not be admitted to more than one program or one service category at the same time. The only allowable exceptions are: (1) for case management services from a CDR

for clients who are also open at a treatment program; and (2) for clients receiving methadone in one program while receiving other specialized treatment in another.

14. The CA must communicate data collection, recording and reporting requirements to local providers as part of the contractual documentation. CAs may not add to or modify any of the above to conflict with or substantively affect State policy and expectations as contained herein.

15. This document contains several references to data entry, editing, and correction by the CA. These references are not meant to preclude the program from data entry, editing, and correction. MDCH encourages data entry at the program level as long as all the criteria for reporting content and editing are met.

16. Statements of MDCH policy, clarifications, modifications, or additional requirements may be necessary and warranted. Documentation shall be forwarded accordingly.

17. Treatment clients who have not had any treatment activity in a 30-day period shall be considered inactive and their case discharged. A treatment discharge record should be completed and submitted; the effective date of discharge would be the last date of actual contact with the program. The record should be completed and submitted based on the clients status as of the last contact; records with all data items marked as unknown or left blank are not acceptable.

18. A logical relationship between the encounter record and the admission, discharge, and SARF records must exist. The HCPCS and/or revenue codes from the encounter record must match the correct service category in the admission, discharge, and SARF records. Also, for each 837encounter record, the client must also have either admission date in the SARF record for assessment services or an admission date in the admission record for treatment services. The client's 837 From Service Date is to be equal to or greater than the SARF admission or treatment date, respectively. The client's 837 To Service Date is to be equal or less than the discharge file discharge date from treatment if present.

July, 2002

Appendix B Encounter Error Listing

The Encounter Error Listing is found on the following landscape pages.

Encounter Error Listing As Of 02/19/03

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20000	File contains unreadable characters.	RB	Reject batch	General file edit	D/I/P		
20015	Submitter Identifier is missing (is spaces or blanks).	RB	Reject batch	1000A, NM109	D/I/P	Submitter Name	Submitter Primary Identification Number
20016	Submitter Identifier is not a valid submitter ID.						
20017	Submitter Identifier is inconsistent between ISA06 and 1000A NM109						
20020	Submission Number is missing (is spaces or blanks).	RB	Reject batch	HDR, BHT03	D/I/P	Beginning Of Hierarchical Transaction	Originator Application Transaction ID
20021	Submission Number is not an alphanumeric value.						
20022	Submission Number has already been used on a prior batch.						
20025	Transaction Type Code not for encounters.	RB	Reject batch	HDR, BHT06	D/I/P	Beginning Of Hierarchical Transaction	Claim or Encounter ID (Transaction Type Code)
20030	Transmission Type Code (Record Category) is missing (is spaces or blanks). Cannot edit the remainder of the record.	RB	Reject batch	HDR, REF02	D/I/P	Transmission Type Identification	Transmission Type Code
20031	Transmission Type Code (Record Category) is not equal to 004010X096, 004010X097 or 004010X098 for record category D, I or P. Cannot edit the remainder of the record.						
20050	Other Payer Primary Identifier (e.g., Health Plan ID) is missing (is zero, spaces, blanks, or null) for record category D, I or P.	RE	Reject encounter	2330B, NM109	D/I/P	Other Payer Name	Other Payer Primary Identifier
20051	None of the Other Payer Primary Identifiers are valid Capitated Plans for record category D, I or P.						
20052	There is an invalid combination of Other Payer Primary Identifiers. The valid combinations are: • Exactly one MQHP, CA, or PHP • Exactly one PHP and one CMHSP Any other combination of Other Payer Primary Identifiers (including none or more than two) is ambiguous and will cause this error.						
20053	The Capitated Plan Identifier is not valid for the Submitter Identifier for record category D, I or P.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20055	Other Payer Secondary Identifier (Encounter Reference Number) is missing (is spaces, blanks or zeroes) for record category D, I or P.	RE	Reject encounter	2330B, REF02	D/I/P	Other Payer Secondary Identification and Reference Number	Other Payer Secondary Identifier
20056	Other Payer Secondary Identifier (Encounter Reference Number) is not an alphanumeric value for record category D, I or P.						
20057	Service Line Counter (Encounter Detail Line Number) is missing (is spaces, blanks or zeroes) for record category D, I or P.	RE	Reject encounter	2400, LX01	D/I/P	Service Line Number	Line Counter
20058	If record category I, Service Line Counter (Encounter Detail Line Number) is not between 01 and 999. If record category D or P Encounter Detail Line Number is not between 01 and 50.						
20059	Service Line Counter(s) [Encounter Detail Line Number(s)] not started with one or not sequentially numbered.						
20060	Claim Frequency Code (Record Type) is missing (is spaces, blanks or zeroes) for record category D, I or P.	RE	Reject encounter	2300, CLM05-3	D/I/P	Claim Information	Claim Frequency Code
20061	Claim Frequency Code (Record Type) is invalid for record category D, I or P.						
20100	Subscriber Primary Identifier (Medicaid ID) is missing (is spaces, blanks or zeroes) and MQHP encounter for record category D, I or P.	RE	Reject encounter	2010BA, NM109	D/I/P	Subscriber Name	Subscriber Primary Identifier (Medicaid ID)
20101	Subscriber Primary Identifier (Medicaid ID) does not exist in the Medicaid eligibility file and MQHP encounter for record category D, I or P.						
20102	Subscriber Primary Identifier (Medicaid ID) is missing (is spaces, blanks or zeroes) and CMH or SA encounter for record category D, I or P.	IO	Info only				
20103	Subscriber Primary Identifier (Medicaid ID) does not exist in the Medicaid eligibility file and CMH or SA encounter for record category D, I or P.						
20104	Subscriber SSN ID present, not numeric and MQHP encounter for record category D, I or P.	RE	Reject encounter	2010BA, NM109 2010BA, REF02	D/I/P	Subscriber Name	Subscriber Primary Identifier/Supplemental Identifier (SSN ID)
20105	Batch is for CMH or SA and Other Insured Identifier (Submitter's Subscriber Unique ID) is missing (is spaces, blanks or zeroes) for record category D, I or P.	RE	Reject encounter	2330A, NM109	D/I/P	Other Subscriber Name	Other Insured Identifier

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20106	Batch is for SA and Other Insured Identifier (Submitter's Subscriber Unique ID) present and does not exist in the applicable SA QI file for record category I, D or P.						
20107	Batch is for CMH and no match to the applicable CMH QI file for record category D, I or P can be made for the combination of: • Other Insured Identifier (Submitter's Subscriber Unique ID), • Other Payer Primary Identifier equal to the QI PHP identifier, • Other Payer Primary Identifier equal to the QI CMH identifier, and • From Service Date falls within the fiscal year of the last reporting date QI data sent for the applicable fiscal year.						
20108	Subscriber Primary Identifier (Child Identification Number) is missing (is spaces, blanks or zeroes) and MIChild encounter for record category D, I or P.	RE	Reject encounter	2010BA, NM109	D/I/P	Subscriber Name	Subscriber Primary Identifier (Child Identification Number)
20109	Subscriber Primary Identifier (Child Identification Number) does not exist in the MIChild eligibility file and MQHP, BC/BS, or capitated dental MIChild encounter for record category D, I or P.						
20140	Admission Date is missing but yet the revenue code has a Room and Board Designation for record category I for Inpatient Type of Bill.	RE	Reject encounter	2300, DTP03 (P, D and I for inpatient encounters only)	I	Admission Date/Hour	Admission Date and Hour/ Related Hospitalization Admission Date
20141	Admission Date present - Invalid date or date is in an invalid format for record category I for Inpatient Type of Bill.						
20142	Admission Date present and is not less than or equal to the run date of this edit run for record category I for Inpatient Type of Bill.						
20143	Admission Date present and is greater than the Discharge date for record category I for Inpatient Type of Bill.						
20144	Admission date is not equal or less than run date for record category D or P.	IO	Info only		D/ P		
20145	Admission Date present but an invalid date or date is in an invalid format for record category D or P.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20148	Statement Through Date/Related Hospitalization Discharge Date is missing but yet the Revenue Code indicates an admission with Room and Board charges and the Discharge Status indicates that a discharge occurred for record category I for Inpatient Type of Bill.	RE	Reject encounter	2300, DTP03 (I for inpatient encounters only)	I	Statement Dates	Statement Through Date/ Related Hospitalization Discharge Date
20149	Statement Through Date/ Related Hospitalization Discharge Date exists but yet Admission Date is missing for record category I for Inpatient Type of Bill.						
20150	Statement Through Date/ Related Hospitalization Discharge Date is an invalid date for record category I for Inpatient Type of Bill.						
20151	Statement Through Date/ Related Hospitalization Discharge Date is less than the Admission Date for record category I for Inpatient Type of Bill.						
20152	Statement Through Date/ Related Hospitalization Discharge Date is not less than or equal to the run date of this edit run for record category I for Inpatient Type of Bill.						
20155	Patient Status Code (Discharge Status) is not a valid code for record category I for Inpatient Type of Bill.	IO	Info only	2300, CL103 (I only)	I	Institutional Claim Code	Patient Status Code
20156	Patient Status Code (Discharge Status) is missing but yet the revenue code has a Room and Board Designation for record category I for Inpatient Type of Bill.						
20170	Service Date is missing (is spaces, blanks or zeroes) for record category D or P or I for Outpatient Type of Bill.	RL	Reject line	2300, DTP03 (D only) 2400, DTP03	D/I/P	Date - Service (D only) Service Line Date	Service Date
20171	Service Date - Invalid date or date is not in the format CCYYMMDD for record category D or P or I for Outpatient Type of Bill.						
20172	Service Date is not less than or equal to the run date of this Edit Run for record category D or P or I for Outpatient Type of Bill.						
20175	Statement From Date is missing (is spaces, blanks or zeroes) for record category I.	RE	Reject encounter	2300, DTP03 (I only)	I	Statement Dates	Statement From Date
20176	Statement From Date - Invalid date or date is not in the format CCYYMMDD for record category I.						
20177	Statement From Date is not less than or equal to the run date of this Edit Run for record category I.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20190	Taxonomy Code is not a valid taxonomy code for record category I	IO	Info only	2000A, PRV03 2310E, PRV03 (I only)	I	Servicing Facility Provider Specialty Information	Servicing Facility Provider Taxonomy /Specialty Code
20191	Taxonomy Code is not a valid taxonomy code for record category D or P	IO	Info only	2000A, PRV03 (D and P only) 2310B, PRV03 (D and only) 2420A, PRV03 (D and only)	D/P	Billing/Rendering Provider Specialty Information	Rendering (Servicing) Provider Taxonomy /Specialty Code
20200	Primary Diagnosis Code is not a valid diagnosis code for record category I.	RE	Reject encounter	2300, HI01-2	I	Health Care/ Principle, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	Diagnosis Code
20201	Primary Diagnosis Code is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.	IO	Info only				
20202	Primary Diagnosis Code is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20203	Primary Diagnosis Code is missing (is zeroes, blanks or spaces) for record category I.	RE	Reject encounter				
20204	Admission Diagnosis Code is present and the Revenue Code indicates an admission with Room and Board charges and admission diagnosis code is not valid for record category I.	IO	Info only	2300, HI02-2 (I only)	I	Principle, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	Diagnosis Code
20205	Admission Diagnosis Code is missing (is zeroes, blanks or spaces) but the Revenue Code indicates an admission with Room and Board charges for record category I.						
20206	Admission Diagnosis Code is not appropriate for the subscriber's age on the applicable QI or Medicaid eligibility file for record category I.						
20207	Admission Diagnosis Code is not a valid diagnosis code for record category I.						
20208	Admission Diagnosis Code is not appropriate for the subscriber's gender for record category I according to the QI or Medicaid eligibility file.						
20209	Other Diagnosis Code 1 exists but yet Primary Diagnosis Code is missing for record category I.	IO	Info only	2300, HI01-2	I	Health Care/ Other Diagnosis	Diagnosis Code Other - 1

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20210	Other Diagnosis 1 Code is not a valid diagnosis code for record category I.					Information	
20211	Other Diagnosis Code 1 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20212	Other Diagnosis Code 1 is not appropriate for the subscriber's gender for record category-I according to the applicable Medicaid Eligibility File or QI Files.						
20213	Other Diagnosis Code 2 exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI02-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 2
20214	Other Diagnosis Code 2 is not a valid diagnosis code for record category I.						
20215	Other Diagnosis Code 2 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20216	Other Diagnosis Code 2 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20217	Other Diagnosis Code 2 exists but yet, Primary Diagnosis Code is missing for record category I						
20218	Other Diagnosis Code 3 exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI03-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 3
20219	Other Diagnosis Code 3 is not a valid diagnosis code for record category I.						
20220	Other Diagnosis Code 3 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20221	Other Diagnosis Code 3 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20222	Other Diagnosis Code 3 exists but yet, Primary Diagnosis Code is missing for record category I.						
20223	Other Diagnosis Code 4 exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI04-2 (I only)	I	Health Care/ Other Diagnosis	Diagnosis Code Other - 4

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20224	Other Diagnosis Code 4 is not a valid diagnosis code for record category I.					Information	
20225	Other Diagnosis Code 4 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files e.						
20226	Other Diagnosis Code 4 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20227	Other Diagnosis Code 4 exists but yet, Primary Diagnosis Code is missing for record category I.						
20228	Other Diagnosis Code 5 exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI05-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 5
20229	Other Diagnosis Code 5 is not a valid diagnosis code for record category I.						
20230	Other Diagnosis Code 5 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20231	Other Diagnosis Code 5 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20232	Other Diagnosis Code 5 exists but yet, Primary Diagnosis Code is missing for record category I.						
20233	Other Diagnosis Code 6 exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI06-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 6
20234	Other Diagnosis Code 6 is not a valid diagnosis code for record category I.						
20235	Other Diagnosis Code 6 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20236	Other Diagnosis Code 6 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20237	Other Diagnosis Code 6 exists but yet, Primary Diagnosis Code is missing for record category I.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20238	Other Diagnosis Code 7 exists but yet one of the previous Diagnosis is missing for record category I.	IO	Info only	2300, HI07-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 7
20239	Other Diagnosis Code 7 is not a valid diagnosis code for record category I.						
20240	Other Diagnosis Code 7 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20241	Other Diagnosis Code 7 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20242	Other Diagnosis Code 7 exists but yet, Primary Diagnosis Code is missing for record category I.						
20243	Other Diagnosis Code 8 exists but yet one of the previous Diagnosis is missing for record category I.	IO	Info only	2300, HI08-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 8
20244	Other Diagnosis Code 8 is not a valid diagnosis code for record category I.						
20245	Other Diagnosis Code 8 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20246	Other Diagnosis Code 8 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20247	Other Diagnosis Code 8 exists but yet, Primary Diagnosis Code is missing for record category I.						
20248	Other Diagnosis 9 Code exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI09-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 9
20249	Other Diagnosis 9 Code is not a valid diagnosis code for record category I.						
20250	Other Diagnosis 9 Code is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20251	Other Diagnosis 9 Code is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20252	Other Diagnosis 9 Code exists but yet, Primary Diagnosis Code is missing for record category I.						
20253	Other Diagnosis 10 Code exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI10-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 10
20254	Other Diagnosis 10 Code is not a valid diagnosis code for record category I.						
20255	Other Diagnosis 10 Code is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20256	Other Diagnosis 10 Code is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20257	Other Diagnosis 10 Code exists but yet, Primary Diagnosis Code is missing for record category I.						
20260	Other Diagnosis 11 Code exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI11-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 11
20261	Other Diagnosis 11 Code is not a valid diagnosis code for record category I.						
20262	Other Diagnosis 11 Code is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20263	Other Diagnosis 11 Code is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20264	Other Diagnosis 11 Code exists but yet, Primary Diagnosis Code is missing for record category I.						
20270	Other Diagnosis 12 Code exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI12-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 12
20271	Other Diagnosis 12 Code is not a valid diagnosis code for record category I.						
20272	Other Diagnosis 12 Code is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20273	Other Diagnosis 12 Code is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20274	Other Diagnosis 12 Code exists but yet, Primary Diagnosis Code is missing for record category I.						
20280	Diagnosis Code Pointer 1 missing or invalid (assumed to be primary diagnosis pointer for the line) for record category P.	RL	Reject line	2400, SV107-1 (P only)	P	Professional Service	Diagnosis Code Pointer 1
20281	Diagnosis Code Pointer 1 valid but points to invalid or missing diagnosis code.						
20282	Diagnosis Code Pointer 1 points to a diagnosis code that is not appropriate for the subscriber's age for record category P according to the applicable Medicaid Eligibility File or QI Files.	IO	Info only				
20283	Diagnosis Code Pointer 1 points to a diagnosis code that is not appropriate for the subscriber's gender for record category P according to the applicable Medicaid Eligibility File or QI Files.						
20284	Diagnosis Code Pointer 2 invalid pointer.	IO	Info only	2400, SV107-2 (P only)	P	Professional Service	Diagnosis Code Pointer 2
20285	Diagnosis Code Pointer 2 valid but points to invalid or missing diagnosis codes.						
20286	Diagnosis Code Pointer 2 points to a diagnosis code that is not appropriate for the subscriber's age for record category P according to the applicable Medicaid Eligibility File or QI Files.						
20287	Diagnosis Code Pointer 2 points to a diagnosis code that is not appropriate for the subscriber's gender for record category P according to the applicable Medicaid Eligibility File or QI Files.						
20288	Diagnosis Code Pointer 3 invalid pointer.	IO	Info only	2400, SV107-3 (P only)	P	Professional Service	Diagnosis Code Pointer 3
20289	Diagnosis Code Pointer 3 valid but points to invalid or missing diagnosis codes.						
20290	Diagnosis Code Pointer 3 points to a diagnosis code that is not appropriate for the subscriber's age for record category P according to the applicable Medicaid Eligibility File or QI Files.						
20291	Diagnosis Code Pointer 3 points to a diagnosis code that is not appropriate for the subscriber's gender for record category P according to the applicable Medicaid Eligibility File or QI Files.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20292	Diagnosis Code Pointer 4 invalid pointer.	IO	Info only	2400, SV107-4 (P only)	P	Professional Service	Diagnosis Code Pointer 4
20293	Diagnosis Code Pointer 4 valid but points to invalid or missing diagnosis codes.						
20294	Diagnosis Code Pointer 4 points to a diagnosis code that is not appropriate for the subscriber's age for record category P according to the applicable Medicaid Eligibility File or QI Files.						
20295	Diagnosis Code Pointer 4 points to a diagnosis code that is not appropriate for the subscriber's gender for record category P according to the applicable Medicaid Eligibility File or QI Files.						
20301	Principal Procedure Code was not yet valid at time of service for record category I.	IO	Info only	2300, HI01-2 (I only)	I	Principal Procedure Information	Principal Procedure Code
20302	Principal Procedure Code was no longer valid at time of service for record category I.						
20310	Service Line Revenue Code is missing (is zeroes, blanks or spaces) for record category I.	RL	Reject line	2400, SV201 (I only)	I	Institutional Service Line	Service Line Revenue Code
20311	Service Line Revenue Code is invalid for record category I.						
20312	Service Line Revenue Code was not yet valid at time of service record category I.						
20313	Service Line Revenue Code was no longer valid at time of service record category I.						
20314	Record category I and hospital outpatient type-of-bill and Procedure Code (HCPCS or local procedure codes for CMH and CA data) not present and valid.	IO	Info only	2400, SV202-2 (I only)	I	Institutional Service Line	Procedure Code (HCPCS)
20315	Record category I and home health services type-of-bill, and Procedure Code (HCPCS or local procedure codes for CMH and CA data) not present and valid.	RL	Reject line				
20316	Procedure Code (HCPCS or local procedure codes for CMH and CA data) was not yet valid at time of service for record category I.	IO	Info only				
20317	Procedure Code (HCPCS or local procedure codes for CMH and CA data) was no longer valid at time of service for record category I.						
20319	Service Line Procedure Code is missing (is zeroes, blanks or spaces) for record category P.	RL	Reject line	2400, SV301-2 (D only)	D/P	Dental/Professional Service	Procedure Code

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20320	Service Line Procedure Code is invalid for record category D or P.			2400, SV101-2 (P only)			
20321	Service Line Procedure Code was not yet valid at time of service record category D or P.						
20322	Service Line Procedure Code was no longer valid at time of service record category D or P.						
20330	Procedure Code Modifier 1 exists but yet Procedure Code is missing (is zeroes, blanks or spaces) for record category I or P.	IO	Info only	2400, SV202-3 (I only) 2400, SV101-3 (P only)	I/P	Institutional/Professional Service Line	Procedure Modifier 1
20331	Procedure Code Modifier 1 is not a valid HCPCS procedure code modifier for record category I or P.						
20334	Procedure Code Modifier 2 exists but yet Procedure Code is missing (is zeroes, blanks or spaces) for record category I or P.	IO	Info only	2400, SV202-4 (I only) 2400, SV101-4 (P only)	I/P	Institutional/Professional Service Line	Procedure Modifier 2
20335	Procedure Code Modifier 2 exists but yet Procedure Code Modifier 1 is missing (is zeroes, blanks or spaces) for record category I or P.						
20336	Procedure Code Modifier 2 is not a valid HCPCS procedure code modifier for record category I or P.						
20340	Procedure Code Modifier 3 exists but yet Procedure Code is missing (is zeroes, blanks or spaces) for record category I or P.	IO	Info only	2400, SV202-5 (I only) 2400, SV101-5 (P only)	I/P	Institutional/Professional Service Line	Procedure Modifier 3
20341	Procedure Code Modifier 3 exists but yet one of the prior Procedure Code Modifiers is missing (is zeroes, blanks or spaces) for record category I or P.						
20342	Procedure Code Modifier 3 is not a valid HCPCS procedure code modifier for record category I or P.						
20345	Procedure Code Modifier 4 exists but yet Procedure Code is missing (is zeroes, blanks or spaces) for record category I or P.	IO	Info only	2400, SV202-6 (I only) 2400, SV101-6 (P only)	I/P	Institutional/Professional Service Line	Procedure Modifier 4
20346	Procedure Code Modifier 4 exists but yet one of the prior Procedure Code Modifiers is missing (is zeroes, blanks or spaces) for record category I or P.						
20347	Procedure Code Modifier 4 is not a valid HCPCS procedure code modifier for record category I or P.						
20350	Product Or Service (Procedure) ID Qualifier missing and there is a procedure code for record category P or D.	IO	Info only	2400, SV202-1 (I only)	D/I/P	Institutional/Dental/Professional Service	Product/Service ID Qualifier

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20351	Product Or Service (Procedure) ID Qualifier missing and there is a HCPCS Procedure Code for record category I.			2400, SV301-1 (D only) 2400, SV101-1 (P only)			
20400	Facility Type Code (Place of Service) is missing (is zeroes, blanks or spaces) for record category D or P.	IO	Info only	2300, CLM05-1 (D and P only) 2400, SV303 (D only) 2400, SV105 (P only)	D/P	Claim Information Dental/Professional Service	Facility Type Code
20401	Facility Type Code (First Two Digits of Type of Bill) is not a valid UB place of service code per the UB92 Type of Bill valid values for record category I.	IO	Info only	2300, CLM05-1 (I only) 2300, CLM05-3 (I only)	I	Claim Information	Facility Type Code
20402	Facility Type Code (Place of Service) is not a valid place of service code for record category D or P.	IO	Info only	2300, CLM05-1 (D and P only) 2400, SV303 (D only) 2400, SV105 (P only)	D/P	Claim Information Dental/Professional Service	Facility Type Code
20403	Facility Type Code (First Two Digits of Type of Bill) is missing (is zeros, blanks or spaces) for record category I.	IO	Info only	2300, CLM05-1 (I only) 2300, CLM05-3 (I only)	I	Claim Information	Facility Type Code
20410	Service Line Units (Quantity) is missing (is zeroes, blanks or spaces) for record category D, I or P.	RL	Reject line	2400, SV205 (I only) 2400, SV306 (D only) 2400, SV104 (P only)	D/I/P	Institutional/Dental/Professional Service Line	Service Line Units/Procedure Count
20411	Service Line Units (Quantity) is less than 0 or not numeric for record category D, I or P.						
20420	Adjudication Date is missing (is spaces, blanks or zeroes) for a payer at both the encounter and service line level for record category D, I or P. Value changed to null.	IO	Info only	2430, DTP03 2330B, DTP03	D/I/P	Service Line Adjudication Date Claim Adjudication Date	Adjudication Or Payment Date
20421	Claim Adjudication Date - Invalid date or date is not in the format CCYYMMDD for record category D, I or P. Value changed to null.			2330B, DTP03		Claim Adjudication Date	Adjudication Or Payment Date
20423	Service Line Adjudication Date - Invalid date or date is not in the format CCYYMMDD for record category D, I or P. Value changed to null.			2430, DTP03		Service Line Adjudication Date	Adjudication Or Payment Date
20471	Reference Identification/Billing Provider Secondary ID Number (Medicaid ID) is missing and a Medicaid encounter for record category D, I or P.	IO	Info only	2010AA, REF02	D/I/P	Billing Provider Secondary Identification	Reference Identification/Billing Provider Secondary ID Number (Medicaid ID)
20500	Billing Provider Qualifier (Billing Provider SSN or EIN ID) is missing (is spaces, blanks or zeroes) for record category D, I or P for	IO	Info only	2010AA, NM108	D/I/P	Billing Provider	Identification Code

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
	MQHP or SA.					Name	Qualifier
20501	Billing Provider Primary ID Number (SSN or EIN) missing for record category D, I or P for MQHP or SA.	RE	Reject encounter	2010AA, NM109	D/I/P	Billing Provider Name	Billing Provider Primary Identifier
20502	Laboratory or Facility Primary Identifier missing for record category I for MQHP.	RE	Reject encounter	2010AA, NM109 (I only) 2010AB, NM109 (I only) 2310E, NM109 (I only)	I	Service Facility Name	Laboratory or Facility Primary Identifier
20503	Rendering Provider Identification (SSN or EIN) missing for record category D or P for MQHP.	RL	Reject line	2010AA, NM109 (D and P only) 2010AB, NM109 (D and P only) 2310B, NM109 (D and P only) 2420A, NM109 (D and P only)	D/P	Rendering Provider Name	Rendering Provider Primary Identifier
20530	Rendering Provider Secondary Identification Number (State License Number or Medicaid ID) is missing and a Medicaid encounter for record category D or P.	IO	Info only	2010AA, REF02 (D and P only) 2010AB, REF02 (D and P only) 2310B, REF02 (D and P only) 2420A, REF02 (D and P only)	D/I/P	Billing/Pay-to/Rendering Provider Name	Reference Identification/Billing/Pay-to/Rendering Provider Secondary Identification Number (State License Number ID or Medicaid ID)
20531	Servicing Facility Provider Secondary Identification Number (State License Number or Medicaid ID) is missing and a Medicaid encounter for record category I.			2010AA, REF02 (I only) 2010AB, REF02 (I only) 2310E, REF02 (I only)		Billing/Pay-to Provider or Service Facility Name	Reference Identification/Billing/Pay-To/Service Facility Provider Secondary Identification Number (State License Number ID or Medicaid ID)
20570	Submitted Charge Amount (Monetary Amount) missing - blank or null for record category D or P.	IO	Info only	2400, SV302 (D only) 2400, SV102 (P only)	D/P	Dental/Professional Service	Submitted Charge Amount
20571	Line Item Charge Amount (Monetary Amount) missing - blank or null for record category I.	IO	Info only	2400, SV203 (I only)	I	Institutional Service Line	Line Item Charge Amount
20572	COB Payer Paid Amount and Service Line Paid Amount both missing (blank or null) for record category P or D.	IO	Info only	2320, AMT02 2430, SVD02	D/P	COB Payer Paid Amount	Payer Paid Amount Service Line Paid

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
						Line Adjudication Information	Amount
20573	Other Payer Allowed Amount missing (blank or null) for record category I, P, or D.	IO	Info only	2320, AMT02	D/I/P	COB Allowed Amount	Allowed Amount
20574	Adjusted Amount missing (blank or null) at both the claim level and the service line level and the Total Submitted Charges do not equal the COB Payer Paid Amount for record category P, or D	IO	Info only	2320, CAS03 2430, CAS03	D/I/P	Claim Level Adjustments Line Adjustment	Adjusted Amount - Claim Level Adjusted Amount - Line Level
20590	Revenue Code equal 100-219 and Service Line Rate Amount (Unit Rate) blank or null for record category I.	IO	Info only	2400, SV206 (I only)	I/P	Institutional Service Line	Service Line Rate Amount
20610	Special Program Code not a valid value, value set to null for record category D or P.	IO	Info only	2300, CLM12 (D and P only)	D/P	Claim Information	Special Program Code
20611	EPSDT Indicator not a valid value (Y or N), value set to null for record category P.	IO	Info only	2400, SV111 (P only)	P	Claim Information	EPSDT Indicator
20612	Oral Cavity Designation Code is missing for record category D.	IO	Info only	2400, SV304	D	Dental Service	Oral Cavity Designation Code
20613	Oral Cavity Designation Code is not valid for record category D.						
20614	Tooth Number is present, but is not a valid value for record category D.	RL	Reject line	2400, TOO02	D	Tooth Information	Tooth Number
20615	Tooth Surface Code is present, but is not a valid value for record category D.	RL	Reject line	2400, TOO03	D	Tooth Information	Tooth Surface Code
20700	Original Other Payer Secondary Identifier (Encounter Reference Number) - encounter already exists for record category D, I or P.	RE	Reject encounter	2330B, REF02	D/I/P	Other Payer Secondary Identification and Reference Number	Other Payer Secondary Identifier (Encounter Reference Number)
20701	Replacement Other Payer Secondary Identifier (Encounter Reference Number) - no encounter exists to replace for record category D, I or P.						
20702	Void Other Payer Secondary Identifier (Encounter Reference Number) - no encounter exists to void for record category D, I or P.						
20703	All service lines for the encounter were rejected; therefore, encounter rejected for record category D, I or P.	RE	Reject encounter	General file edit	D/I/P		
20704	This record was superceded by another input record for record category D, I or P.	IO	Info only				
20801	SA Encounter HCPCS procedure code not compatible with admission service category	RE	Reject encounter	2400, SV202-2 (I only) 2400, SV101-2 (P only)	I/P	Institutional Service Line/ Professional Service	Procedure Code (HCPCS)

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20802	SA Encounter reflect HCPCS of assessment and the service date not while subscriber was in an admitted status or within one month after SARF date of admission	RE	Reject encounter	2400, DTP03	I/P	Service Line Date	Service Date
20803	SA Encounter reflect HCPCS other than assessment and the service date not while subscriber was in an admitted status						
20807	Subscriber SSN ID present, not numeric and CMH or SA encounter for record category D, I or P.	IO	Info only	2010BA, NM109 2010BA, REF02	D/I/P	Subscriber Name	Subscriber Primary Identifier/Supplemental Identifier (SSN ID)
99999	This is the last message of your batch transmission.	IO	Info only	General file edit	D/I/P		

Appendix C 837 Encounter Error Return File

C.1 837 Encounter Error Return File Header

This 837 Error Return File EDI Header is a single record that precedes the error report (Error Return File) that gives the entity that submitted data files detail on error detected by the Encounter Data Warehouse edits process.

Table C-1: 837 Encounter Error Return File Header Layout

Field Name	Type	Size	Begin	End	Comments
EDI-HEADER-RECORD					
EDI-TYPE	X(4)	4	1	4	Value “HDDR
EDI-APP	X(4)	2	5	6	Value “MA”
EDI-USER	X(4)	4	7	10	Value “MMIS
EDI-USER-ID	X(4)	4	11	14	Value “00XX” (“XX” = Service Bureau Claim ID
EDI-DATE-CYMD	X(8)	8	15	22	Creation Date (format is YYYYMMDD)
EDI TRANSFER DATE					Transfer date or use creation date
TRANSFER-YYYY	X(4)	4	23	26	
TRANSFER-MM	X(2)	2	27	28	
TRANSFER-DD	X(2)	2	29	30	
TRANSFER-HH	X(2)	2	31	32	
TRANSFER-MINUTE	X(2)	2	33	34	
EDI-FILE					
EDI-FILE-BEG	X(4)	4	35	38	Value "4950"
EDI-RUN-TYPE	X(1)	1	39	39	Value “P” for production or “T” for test
EDI-BATCH	X(3)	3	40	42	Unique batch identifier
FILLER	9(10)	10	43	52	
FILLER	X(101)	101	53	152	

C.2 837 Encounter Error Return File Detail Record

The following defines the 837 Error Return File that reflects the errors detected by the Encounter Data Warehouse edit process. Information on each error is included in the fields that are part of a record that describes the error.

Table C-2: CA 837 Encounter Error Return File Detail Record Layout

Field Name	Type	Size	Begin	End	Comments
ENCOUNTER-ERROR-RETURN-RECORD					
SUBMITTER-ID	X(4)	4	1	4	Also called "autobiller ID" or "service bureau" - identifier of the organization that physically transmits the data.
CAPITATED-PLAN-ID	X(20)	20	5	24	Also called "Health Plan ID" or "Primary Payer ID", this is the ID of the Qualified Health Plan, Community Mental Health Services Provider or Coordinating Agency, etc.
RELATED-PLAN-ID	X(20)	20	25	44	Plan ID of a related plan, if any (e.g. the Prepaid Health Plan corresponding to a CMHSP.)
SUBMISSION-NUMBER	X(20)	20	45	64	Number identifying a batch - may not be reused by the same capitated health plan.
ENCOUNTER-REFERENCE-NUMBER	X(30)	30	65	94	The Encounter Reference Number assigned by the capitated health plan.
ENCOUNTER-LINE-NUMBER	X(3)	3	95	97	The Encounter Line Number assigned by the capitated health plan.
RECORD-TYPE	X(1)	1	98	98	Values are: "O" = Original "R" = Replacement "V" = Void
RECORD-CATEGORY	X(1)	1	99	99	Values are: "P" = Professional "I" = Institutional "D" = Dental
ERROR-NUMBER	X(5)	5	100	104	Format is "20nnn". Reference Section Refer to Appendix B for Edit Error List.
ERROR-SEVERITY	X(2)	2	105	106	Values are: "RB" = Reject batch "RE" = Reject encounter "RL" = Reject line "IO" = Information only
ERROR-FIELD	X(20)	20	107	126	First 20 positions of erroneous field
BATCH-SEQUENCE-NUMBER	X(8)	8	127	134	An internally generated number

Field Name	Type	Size	Begin	End	Comments
					indicating the relative position of a batch within an input file
ASSIGNED-SEQ-ERN	X(13)	13	135	147	ASSIGNED-SEQ-ERN, ASSIGNED-SEQ-TYPE and ASSIGNED-SEQ-ELN are internal Encounter Reference Numbers, Types and Line Numbers assigned by the edit program for its own use. However, the ASSIGNED-SEQ-ERN values will be assigned sequentially in the order in which the encounters appear in the input file, so it can also be used as a sequence number to sort the error results in that order.
ASSIGNED-SEQ-TYPE	X(2)	2	148	149	Type field indicating source of encounter: "60" = CMH "61" = SA "62" = MIChild "63" = Medicaid "64" = Delta Dental
ASSIGNED-SEQ-ELN	X(3)	3	150	152	Internal ELN assigned to this encounter line by the system

C.3 837 Encounter Error Return File Trailer Record

This 837 Error Return File EDI Trailer record follows the errors detected by the Encounter Data Warehouse edit process.

Table C-3: CA 837 Encounter Error Return File Trailer Record Layout

Field Name	Type	Size	Begin	End	Comments
EDI-HEADER-RECORD					
EDI-TYPE	X(4)	4	1	4	Value "TRLR"
EDI-APP	X(4)	2	5	6	Value "MA"
EDI-USER	X(4)	4	7	10	Value "MMIS"
EDI-USER-ID	X(4)	4	11	14	Value "00XX" ("XX" = Service Bureau Claim ID
EDI-DATE-CYMD	X(8)	8	15	22	Creation Date (format is YYYYMMDD)
EDI TRANSFER DATE					Transfer date or use creation date
TRANSFER-YYYY	X(4)	4	23	26	
TRANSFER-MM	X(2)	2	27	28	
TRANSFER-DD	X(2)	2	29	30	
TRANSFER-HH	X(2)	2	31	32	
TRANSFER-MINUTE	X(2)	2	33	34	
EDI-FILE					
EDI-FILE-BEG	X(4)	4	35	38	Value "4950"
EDI-RUN-TYPE	X(1)	1	39	39	Value "P" for production or "T" for test
EDI-BATCH	X(3)	3	40	42	Unique batch identifier
FILLER	9(10)	10	43	52	
FILLER	X(101)	101	53	152	

Appendix D Substance Abuse Quality Improvement (QI) File

D.1 SA SARF File Format

D.1.1 SA SARF Header Format

Field Name	Type	Size	Begin	End	Comments
Note: Any errors on the HDDR or TRLR record will cause the entire file to reject and be returned to the appropriate submitter via the Data Exchange Gateway (DEG) via the 4825 file.					
EDI TYPE	Text	4	1	4	"HDDR"
EDI APP	Text	2	5	6	"MA"
EDI USER					
EDI USER - prefix	Text	5	7	11	"DCH00" (DCH zero zero)
EDI USER - CA ID	Text	2	12	13	Service Bureau ID
EDI USER - suffix	Text	1	14	14	Blank
EDI CREATION DATE	Text	8	15	22	YYYYMMDD
EDI TRANSFER DATE	Text	8	23	30	YYYYMMDD
EDI TRANSFER TIME	Text	4	31	34	HHMM
EDI FILE NAME	Text	4	35	38	4825
EDI RUN TYPE	Text	1	39	39	"P" for production or "T" for test
EDI BATCH IDENTIFIER	Text	3	40	42	Unique batch identifier assigned by CA
FILLER	Text	110	43	152	

D.1.2 SA SARF Input File Format

Field Name	Type	Size	Begin	End	Comments
Note: A SARF Record is stored using the following key values: CA Payer ID, License Number, Social Security Number, CA Client ID, Admission Date, Service Category. Each SARF Record must have the following unique key values: CA Payer ID, License Number, Social Security Number, CA Client ID, Admission Date, Service Category.					
Record Type	Text	1	1	1	A=Admission D=Discharge S=SARF X=Transition-out Y=Transition-in
Submission Type	Text	1	2	2	A=Add C=Change D=Delete E=Error

<table>
<tr><th>Field Name</th><th>Type</th><th>Size</th><th>Begin</th><th>End</th><th>Comments</th></tr>
<tr><td>CA Payer ID</td><td>Text</td><td>9</td><td>3</td><td>11</td><td>
<table>
<tr><th>CA Code</th><th>CA Name</th></tr>
<tr><td>174462881</td><td>Bay-Arenac</td></tr>
<tr><td>174459975</td><td>Kalamazoo</td></tr>
<tr><td>174456919</td><td>Macomb</td></tr>
<tr><td>174454709</td><td>Washtenaw</td></tr>
<tr><td>174458216</td><td>Pathways (also known as Eastern Upper Peninsula)</td></tr>
<tr><td>174464053</td><td>Genesee</td></tr>
<tr><td>174455644</td><td>Lakeshore</td></tr>
<tr><td>174458190</td><td>Mid-South</td></tr>
<tr><td>174464080</td><td>Kent</td></tr>
<tr><td>174458207</td><td>Northern</td></tr>
<tr><td>174456937</td><td>Oakland</td></tr>
<tr><td>174454718</td><td>Saginaw</td></tr>
<tr><td>174458243</td><td>SEMCA</td></tr>
<tr><td>174456928</td><td>St. Clair</td></tr>
<tr><td>174463350</td><td>Western Upper Peninsula</td></tr>
<tr><td>174456991</td><td>Detroit</td></tr>
</table>
</td></tr>
<tr><td>License Number</td><td>Text</td><td>6</td><td>12</td><td>17</td><td>DCIS License Number</td></tr>
<tr><td>Social Security Number</td><td>Text</td><td>9</td><td>18</td><td>26</td><td></td></tr>
<tr><td>CA Client Identifier</td><td>Text</td><td>11</td><td>27</td><td>37</td><td></td></tr>
<tr><td>Medicaid Identifier</td><td>Text</td><td>8</td><td>38</td><td>45</td><td>Must be blank if not applicable</td></tr>
<tr><td>Admission Type</td><td>Text</td><td>1</td><td>46</td><td>46</td><td>1 = first admission
2 = readmission</td></tr>
<tr><td>Co-Dependent</td><td>Text</td><td>1</td><td>47</td><td>47</td><td>1 = yes
2 = no</td></tr>
<tr><td>Date of Admission</td><td>Text</td><td>8</td><td>48</td><td>55</td><td>CCYYMMDD</td></tr>
<tr><td>Service Category</td><td>Text</td><td>2</td><td>56</td><td>57</td><td>51 = Assessment - CDR
52 = Assessment - non-CDR</td></tr>
<tr><td>Number of Prior Treatments</td><td>Text</td><td>2</td><td>58</td><td>59</td><td></td></tr>
<tr><td>Referral Source</td><td>Text</td><td>2</td><td>60</td><td>61</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>01</td><td>Outpatient</td></tr>
<tr><td>05</td><td>Residential detoxification</td></tr>
<tr><td>06</td><td>Residential</td></tr>
<tr><td>09</td><td>Intensive outpatient</td></tr>
<tr><td>10</td><td>Hospital: SA program</td></tr>
<tr><td>13</td><td>CDR</td></tr>
<tr><td>14</td><td>Other SARF</td></tr>
<tr><td>18</td><td>Prevention</td></tr>
<tr><td>19</td><td>Student assistance program</td></tr>
<tr><td>29</td><td>Other SA Program</td></tr>
<tr><td>30</td><td>Self</td></tr>
<tr><td>31</td><td>Court - driving</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Field Name</th><th>Type</th><th>Size</th><th>Begin</th><th>End</th><th>Comments</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>
<table>
<tr><td>32</td><td>Court - other</td></tr>
<tr><td>33</td><td>Other criminal justice</td></tr>
<tr><td>34</td><td>Police</td></tr>
<tr><td>35</td><td>Secretary of State</td></tr>
<tr><td>36</td><td>Lawyer</td></tr>
<tr><td>37</td><td>Mental Health</td></tr>
<tr><td>38</td><td>Family Independence Agency</td></tr>
<tr><td>39</td><td>Family/friend/relative</td></tr>
<tr><td>40</td><td>Other human services</td></tr>
<tr><td>41</td><td>Employer</td></tr>
<tr><td>42</td><td>Union</td></tr>
<tr><td>43</td><td>Clergy</td></tr>
<tr><td>44</td><td>School</td></tr>
<tr><td>45</td><td>Physician</td></tr>
<tr><td>46</td><td>Hospital (non-substance abuse)</td></tr>
<tr><td>47</td><td>Substance abuse client</td></tr>
<tr><td>48</td><td>Alcoholics Anonymous</td></tr>
<tr><td>49</td><td>Corrections</td></tr>
<tr><td>90</td><td>Other</td></tr>
</table>
</td></tr>
<tr><td>County of Residence</td><td>Text</td><td>2</td><td>62</td><td>63</td><td>Reference Appendix D.5 SA County Codes for a list of valid county codes.</td></tr>
<tr><td>Date of Birth</td><td>Text</td><td>8</td><td>64</td><td>71</td><td>CCYYMMDD</td></tr>
<tr><td>Sex</td><td>Text</td><td>1</td><td>72</td><td>72</td><td>1= Male
2 = Female</td></tr>
<tr><td>Race</td><td>Text</td><td>1</td><td>73</td><td>73</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1</td><td>Native American</td></tr>
<tr><td>2</td><td>Asian or Pacific Islander</td></tr>
<tr><td>3</td><td>African American/Black</td></tr>
<tr><td>4</td><td>White</td></tr>
<tr><td>5</td><td>Hispanic</td></tr>
<tr><td>6</td><td>Multi-racial</td></tr>
<tr><td>8</td><td>Arab American</td></tr>
<tr><td>9</td><td>Refused to provide</td></tr>
<tr><td>0</td><td>Unknown</td></tr>
</table>
</td></tr>
<tr><td>Ethnicity</td><td>Text</td><td>1</td><td>74</td><td>74</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>0</td><td>Not one of listed groups</td></tr>
<tr><td>1</td><td>Puerto Rican</td></tr>
<tr><td>2</td><td>Mexican</td></tr>
<tr><td>3</td><td>Cuban</td></tr>
<tr><td>4</td><td>Other Hispanic</td></tr>
<tr><td>5</td><td>Arab Chaldean</td></tr>
</table>
</td></tr>
<tr><td>Marital Status</td><td>Text</td><td>1</td><td>75</td><td>75</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1</td><td>Never Married</td></tr>
<tr><td>2</td><td>Married/Cohabiting</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Field Name</th><th>Type</th><th>Size</th><th>Begin</th><th>End</th><th>Comments</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>
<table>
<tr><td>3</td><td>Widowed</td></tr>
<tr><td>4</td><td>Divorced</td></tr>
<tr><td>5</td><td>Separated</td></tr>
</table>
</td></tr>
<tr><td>Military Status</td><td>Text</td><td>1</td><td>76</td><td>76</td><td>1 = yes
2 = no</td></tr>
<tr><td>Education</td><td>Text</td><td>2</td><td>77</td><td>78</td><td>00 to 25 number of years of education (e.g., 4 years of college = 16)</td></tr>
<tr><td>Currently in Training/Education</td><td>Text</td><td>1</td><td>79</td><td>79</td><td>4 = in training program
6 = in special education
7 = is attending undergraduate college
0 = not applicable</td></tr>
<tr><td>Employment Status</td><td>Text</td><td>1</td><td>80</td><td>80</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1</td><td>Employed, full time</td></tr>
<tr><td>2</td><td>Employed, part time</td></tr>
<tr><td>3</td><td>Unemployed - laid off, fired, seasonal, actively sought work in last 30 days</td></tr>
<tr><td>4</td><td>Not in competitive labor force - includes homemaker, student age 18 and over, day program participant, resident or inmate of an institution (includes nursing home)</td></tr>
<tr><td>6</td><td>Retired from work</td></tr>
<tr><td>8</td><td>Not applicable to the person (e.g., child under age 18)</td></tr>
</table>
</td></tr>
<tr><td>Primary Substance</td><td>Text</td><td>2</td><td>81</td><td>82</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>00</td><td>None</td></tr>
<tr><td>10</td><td>Alcohol</td></tr>
<tr><td>20</td><td>Heroin</td></tr>
<tr><td>21</td><td>Methadone (illicit)</td></tr>
<tr><td>22</td><td>Other opiates or synthetics</td></tr>
<tr><td>30</td><td>Barbituates</td></tr>
<tr><td>31</td><td>Other sedatives or hypnotics</td></tr>
<tr><td>32</td><td>Other tranquilizers</td></tr>
<tr><td>33</td><td>Benzodiazepines</td></tr>
<tr><td>34</td><td>GHB, GBL</td></tr>
<tr><td>41</td><td>Cocaine</td></tr>
<tr><td>42</td><td>Crack Cocaine</td></tr>
<tr><td>43</td><td>Methamphetamines</td></tr>
<tr><td>44</td><td>Other amphetamines</td></tr>
<tr><td>45</td><td>Methcathinone</td></tr>
<tr><td>50</td><td>Hallucinogens</td></tr>
<tr><td>51</td><td>PCP</td></tr>
<tr><td>52</td><td>Marijuana/hashish</td></tr>
<tr><td>53</td><td>Ecstasy (MDMA, MDA)</td></tr>
<tr><td>54</td><td>Ketamine</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Field Name</th><th>Type</th><th>Size</th><th>Begin</th><th>End</th><th>Comments</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td><table>
<tr><td>60</td><td>Inhalants</td></tr>
<tr><td>61</td><td>Antidepressants</td></tr>
<tr><td>70</td><td>Over-the-counter</td></tr>
<tr><td>72</td><td>Steroids</td></tr>
<tr><td>81</td><td>Talwin and PBZ</td></tr>
<tr><td>91</td><td>Other</td></tr>
</table></td></tr>
<tr><td>Primary Route</td><td>Text</td><td>1</td><td>83</td><td>83</td><td><table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>0</td><td>Not applicable (drug code was “none”)</td></tr>
<tr><td>1</td><td>Oral</td></tr>
<tr><td>2</td><td>Smoking</td></tr>
<tr><td>3</td><td>Inhalation/intranasal (“snorting”)</td></tr>
<tr><td>4</td><td>Injection</td></tr>
<tr><td>5</td><td>Other</td></tr>
</table></td></tr>
<tr><td>Primary Age at first Use</td><td>Text</td><td>2</td><td>84</td><td>85</td><td>2 character age
98 = not applicable (drug code was “none”)</td></tr>
<tr><td>Primary Frequency of Use</td><td>Text</td><td>2</td><td>86</td><td>87</td><td>Number of days drug used in last 30 days
2 characters
00 = not used
30 = used daily
98 = not applicable (drug code was “none”)</td></tr>
<tr><td>Primary Initial Prescription</td><td>Text</td><td>1</td><td>88</td><td>88</td><td>Initially a prescription
0 = not applicable (drug code was “none”)
1 = yes
2 = no</td></tr>
<tr><td>Secondary Substance</td><td>Text</td><td>2</td><td>89</td><td>90</td><td>For list of values, reference Primary Substance</td></tr>
<tr><td>Secondary Route</td><td>Text</td><td>1</td><td>91</td><td>91</td><td>For list of values, reference Primary Route</td></tr>
<tr><td>Secondary Age at First Use</td><td>Text</td><td>2</td><td>92</td><td>93</td><td>2 character age
98 = not applicable (drug code was “none”)</td></tr>
<tr><td>Secondary Frequency of Use</td><td>Text</td><td>2</td><td>94</td><td>95</td><td>Number of days drug used in last 30 days
2 characters
00 = not used
30 = used daily
98 = not applicable (drug code was “none”)</td></tr>
<tr><td>Secondary Initial Prescription</td><td>Text</td><td>1</td><td>96</td><td>96</td><td>Initially a prescription
0 = not applicable (drug code was “none”)
1 = yes
2 = no</td></tr>
<tr><td>Tertiary Substance</td><td>Text</td><td>2</td><td>97</td><td>98</td><td>For list of values, reference Primary Substance</td></tr>
<tr><td>Tertiary Route</td><td>Text</td><td>1</td><td>99</td><td>99</td><td>For list of values, reference Primary Route</td></tr>
</table>

Field Name	Type	Size	Begin	End	Comments
Tertiary Age at First Use	Text	2	100	101	2 character age 98 = not applicable (drug code was "none")
Tertiary Frequency of Use	Text	2	102	103	Number of days drug used in last 30 days 2 characters 00 = not used 30 = used daily 98 = not applicable (drug code was "none")
Tertiary Initial Prescription	Text	1	104	104	Initially a prescription 0 = not applicable (drug code was "none") 1 = yes 2 = no
Total Annual Income	Number	6	105	110	6 characters, rounded to the nearest whole dollar; no decimal points or commas
Program Eligibility: Able to Pay	Number	1	111	111	1 = yes 2 = no
Program Eligibility: Commercial Insurance	Number	1	112	112	1 = yes 2 = no
Program Eligibility: Services Contract	Number	1	113	113	1 = yes 2 = no
Program Eligibility: Medicare	Number	1	114	114	1 = yes 2 = no
Program Eligibility: Medicaid	Number	1	115	115	1 = yes 2 = no
Program Eligibility: Workers Compensation	Number	1	116	116	1 = yes 2 = no
Program Eligibility: Other Public Sources	Number	1	117	117	1 = yes 2 = no
Program Eligibility: CA Resources	Number	1	118	118	1 = yes 2 = no
Program Eligibility: State Medical Plan	Number	1	119	119	1 = yes 2 = no
Program Eligibility: MI Child	Number	1	120	120	1 = yes 2 = no
Program Eligibility: Medicaid Children's Waiver	Number	1	121	121	1 = yes 2 = no
Program Eligibility: Other Payment Source Not Listed Above	Number	1	122	122	1 = yes 2 = no
Correctional Status	Text	2	123	124	<table><tr><th>Code</th><th>Description</th></tr><tr><td>00</td><td>No status with corrections system</td></tr><tr><td>01</td><td>In prison</td></tr><tr><td>02</td><td>In jail</td></tr><tr><td>03</td><td>Paroled from prison</td></tr></table>

<table>
<tr><th>Field Name</th><th>Type</th><th>Size</th><th>Begin</th><th>End</th><th>Comments</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>
<table>
<tr><td>04</td><td>Probation from jail</td></tr>
<tr><td>05</td><td>Juvenile detention center</td></tr>
<tr><td>06</td><td>Court supervision</td></tr>
<tr><td>07</td><td>Interacted with but not under jurisdiction of law enforcement program</td></tr>
<tr><td>08</td><td>Awaiting trial</td></tr>
<tr><td>09</td><td>Awaiting sentencing</td></tr>
<tr><td>10</td><td>Refused to provide information</td></tr>
<tr><td>98</td><td>Unknown</td></tr>
</table>
</td></tr>
<tr><td>Total Arrests - 6 months</td><td>Number</td><td>2</td><td>125</td><td>126</td><td>00 if no arrests</td></tr>
<tr><td>Arrests - Possession/Sales - 6 months</td><td>Number</td><td>2</td><td>127</td><td>128</td><td>00 if no arrests</td></tr>
<tr><td>Arrests - DUI/DWI - 6 months</td><td>Number</td><td>2</td><td>129</td><td>130</td><td>00 if no arrests</td></tr>
<tr><td>Total Arrests - 5 years</td><td>Number</td><td>2</td><td>131</td><td>132</td><td>00 if no arrests</td></tr>
<tr><td>Arrests - Possession/Sales - 5 years</td><td>Number</td><td>2</td><td>133</td><td>134</td><td>00 if no arrests</td></tr>
<tr><td>Arrests - DUI/DWI - 5 years</td><td>Number</td><td>2</td><td>135</td><td>136</td><td>00 if no arrests</td></tr>
<tr><td>Living Arrangement</td><td>Text</td><td>1</td><td>137</td><td>137</td><td>1 = independent
2 = dependent
3 = homeless</td></tr>
<tr><td>Pregnant</td><td>Text</td><td>1</td><td>138</td><td>138</td><td>1 = yes
2 = no</td></tr>
<tr><td>Other Factor 1</td><td>Text</td><td>1</td><td>139</td><td>139</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>0</td><td>None</td></tr>
<tr><td>2</td><td>Adult child</td></tr>
<tr><td>3</td><td>Significant other</td></tr>
<tr><td>4</td><td>Hearing impaired</td></tr>
<tr><td>5</td><td>Visually impaired</td></tr>
<tr><td>6</td><td>Head injury</td></tr>
<tr><td>7</td><td>Developmentally disabled</td></tr>
<tr><td>8</td><td>Mobility impaired</td></tr>
<tr><td>9</td><td>Mental illness</td></tr>
</table>
</td></tr>
<tr><td>Other Factor 2</td><td>Text</td><td>1</td><td>140</td><td>140</td><td>For list of values, reference Other Factor 1</td></tr>
<tr><td>Other Factor 3</td><td>Text</td><td>1</td><td>141</td><td>141</td><td>For list of values, reference Other Factor 1</td></tr>
<tr><td>Primary Language Spoken</td><td>Text</td><td>3</td><td>142</td><td>144</td><td>For list of values, reference http://lcweb.loc.gov/standards/iso639-2/langhome.html</td></tr>
<tr><td>Error ID</td><td>Numeric</td><td>8</td><td>145</td><td>152</td><td></td></tr>
</table>

D.1.3 SA SARF Trailer Format

Field Name	Type	Size	Begin	End	Comments
Note: Any errors on the HDDR or TRLR record will cause the entire file to reject and be returned to the appropriate submitter via the Data Exchange Gateway (DEG) via the 4825 file.					
EDI TYPE	Text	4	1	4	"TRLR"
EDI APP	Text	2	5	6	"MA"
EDI USER					
EDI USER - prefix	Text	5	7	11	"DCH00" (DCH zero zero)
EDI USER - CA ID	Text	2	12	13	Service Bureau ID
EDI USER - suffix	Text	1	14	14	Blank
EDI CREATION DATE	Text	8	15	22	YYYYMMDD
EDI TRANSFER DATE	Text	8	23	30	YYYYMMDD
EDI TRANSFER TIME	Text	4	31	34	HHMM
EDI FILE NAME	Text	4	35	38	4825
EDI RUN TYPE	Text	1	39	39	"P" for production or "T" for test
EDI BATCH IDENTIFIER	Text	3	40	42	Unique batch identifier assigned by CA
EDI RECORD COUNT	Number	6	43	48	Number of records in a file including the header and trailer
FILLER	Text	104	49	152	

D.2 SA Admission File Format

D.2.1 SA Admission Header Format

Field Name	Type	Size	Begin	End	Comments
Note: Any errors on the HDDR or TRLR record will cause the entire file to reject and be returned to the appropriate submitter via the Data Exchange Gateway (DEG) via the 4823 file.					
EDI TYPE	Text	4	1	4	"HDDR"
EDI APP	Text	2	5	6	"MA"
EDI USER					
EDI USER - prefix	Text	5	7	11	"DCH00" (DCH zero zero)
EDI USER - CA ID	Text	2	12	13	Service Bureau ID
EDI USER - suffix	Text	1	14	14	Blank
EDI CREATION DATE	Text	8	15	22	YYYYMMDD
EDI TRANSFER DATE	Text	8	23	30	YYYYMMDD
EDI TRANSFER TIME	Text	4	31	34	HHMM
EDI FILE NAME	Text	4	35	38	4823
EDI RUN TYPE	Text	1	39	39	"P" for production or "T" for test
EDI BATCH IDENTIFIER	Text	3	40	42	Unique batch identifier assigned by CA
FILLER	Text	132	43	174	

D.2.2 SA Admission Input File Format

Field Name	Type	Size	Begin	End	Comments
Note: An Admission Record is stored using the following key values: CA Payer ID, License Number, Social Security Number, CA Client ID, Admission Date, Admission Time of Day, Admission Service Category. Each Admission Record must have the following unique key values: CA Payer ID, License Number, Social Security Number, CA Client ID, Admission Date, Admission Time of Day.					
Record Type	Text	1	1	1	A=Admission D=Discharge S=SARF X=Transition-out Y=Transition-in
Submission Type	Text	1	2	2	A=Add C=Change D=Delete E=Error

<table>
<tr><th>Field Name</th><th>Type</th><th>Size</th><th>Begin</th><th>End</th><th>Comments</th></tr>
<tr><td>CA Payer ID</td><td>Text</td><td>9</td><td>3</td><td>11</td><td>
<table>
<tr><th>CA Code</th><th>CA Name</th></tr>
<tr><td>174462881</td><td>Bay-Arenac</td></tr>
<tr><td>174459975</td><td>Kalamazoo</td></tr>
<tr><td>174456919</td><td>Macomb</td></tr>
<tr><td>174454709</td><td>Washtenaw</td></tr>
<tr><td>174458216</td><td>Pathways (also known as Eastern Upper Peninsula)</td></tr>
<tr><td>174464053</td><td>Genesee</td></tr>
<tr><td>174455644</td><td>Lakeshore</td></tr>
<tr><td>174458190</td><td>Mid-South</td></tr>
<tr><td>174464080</td><td>Kent</td></tr>
<tr><td>174458207</td><td>Northern</td></tr>
<tr><td>174456937</td><td>Oakland</td></tr>
<tr><td>174454718</td><td>Saginaw</td></tr>
<tr><td>174458243</td><td>SEMCA</td></tr>
<tr><td>174456928</td><td>St. Clair</td></tr>
<tr><td>174463350</td><td>Western Upper Peninsula</td></tr>
<tr><td>174456991</td><td>Detroit</td></tr>
</table>
</td></tr>
<tr><td>License Number</td><td>Text</td><td>6</td><td>12</td><td>17</td><td>DCIS License Number</td></tr>
<tr><td>Social Security Number</td><td>Text</td><td>9</td><td>18</td><td>26</td><td></td></tr>
<tr><td>CA Client Identifier</td><td>Text</td><td>11</td><td>27</td><td>37</td><td></td></tr>
<tr><td>Medicaid Identifier</td><td>Text</td><td>8</td><td>38</td><td>45</td><td>Must be blank if not applicable</td></tr>
<tr><td>Admission Type</td><td>Text</td><td>1</td><td>46</td><td>46</td><td>1 = first admission
2 = readmission</td></tr>
<tr><td>Co-Dependent</td><td>Text</td><td>1</td><td>47</td><td>47</td><td>1 = yes
2 = no</td></tr>
<tr><td>Date of Admission</td><td>Text</td><td>8</td><td>48</td><td>55</td><td>CCYYMMDD</td></tr>
<tr><td>Service Category</td><td>Text</td><td>2</td><td>56</td><td>57</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>11</td><td>Outpatient</td></tr>
<tr><td>21</td><td>Residential detoxification</td></tr>
<tr><td>22</td><td>Residential - short-term (no more than 29 days)</td></tr>
<tr><td>24</td><td>Residential - long-term (30 day or more)</td></tr>
<tr><td>31</td><td>Intensive outpatient</td></tr>
</table>
</td></tr>
<tr><td>Number of Prior Treatments</td><td>Text</td><td>2</td><td>58</td><td>59</td><td>Number as reported</td></tr>
<tr><td>Referral Source</td><td>Text</td><td>2</td><td>60</td><td>61</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>01</td><td>Outpatient</td></tr>
<tr><td>05</td><td>Residential detoxification</td></tr>
<tr><td>06</td><td>Residential</td></tr>
<tr><td>09</td><td>Intensive outpatient</td></tr>
<tr><td>10</td><td>Hospital: SA program</td></tr>
<tr><td>13</td><td>CDR</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Field Name</th><th>Type</th><th>Size</th><th>Begin</th><th>End</th><th>Comments</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>
<table>
<tr><td>14</td><td>Other SARF</td></tr>
<tr><td>18</td><td>Prevention</td></tr>
<tr><td>19</td><td>Student assistance program</td></tr>
<tr><td>29</td><td>Other SA program</td></tr>
<tr><td>30</td><td>Self</td></tr>
<tr><td>31</td><td>Court - driving</td></tr>
<tr><td>32</td><td>Court - other</td></tr>
<tr><td>33</td><td>Other criminal justice</td></tr>
<tr><td>34</td><td>Police</td></tr>
<tr><td>35</td><td>Secretary of State</td></tr>
<tr><td>36</td><td>Lawyer</td></tr>
<tr><td>37</td><td>Mental Health</td></tr>
<tr><td>38</td><td>Family Independence Agency</td></tr>
<tr><td>39</td><td>Family/friend/relative</td></tr>
<tr><td>40</td><td>Other human services</td></tr>
<tr><td>41</td><td>Employer</td></tr>
<tr><td>42</td><td>Union</td></tr>
<tr><td>43</td><td>Clergy</td></tr>
<tr><td>44</td><td>School</td></tr>
<tr><td>45</td><td>Physician</td></tr>
<tr><td>46</td><td>Hospital (non-substance abuse)</td></tr>
<tr><td>47</td><td>Substance abuse client</td></tr>
<tr><td>48</td><td>Alcoholics Anonymous</td></tr>
<tr><td>49</td><td>Corrections</td></tr>
<tr><td>90</td><td>Other</td></tr>
</table>
</td></tr>
<tr><td>County of Residence</td><td>Text</td><td>2</td><td>62</td><td>63</td><td>Reference Appendix D.5 SA County Codes for a list of valid county codes.</td></tr>
<tr><td>Date of Birth</td><td>Text</td><td>8</td><td>64</td><td>71</td><td>CCYYMMDD</td></tr>
<tr><td>Sex</td><td>Text</td><td>1</td><td>72</td><td>72</td><td>1= Male
2 = Female</td></tr>
<tr><td>Race</td><td>Text</td><td>1</td><td>73</td><td>73</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1</td><td>Native American</td></tr>
<tr><td>2</td><td>Asian or Pacific Islander</td></tr>
<tr><td>3</td><td>African American/Black</td></tr>
<tr><td>4</td><td>White</td></tr>
<tr><td>5</td><td>Hispanic</td></tr>
<tr><td>6</td><td>Multi-racial</td></tr>
<tr><td>8</td><td>Arab American</td></tr>
<tr><td>9</td><td>Refused to provide</td></tr>
<tr><td>0</td><td>Unknown</td></tr>
</table>
</td></tr>
<tr><td>Ethnicity</td><td>Text</td><td>1</td><td>74</td><td>74</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>0</td><td>Not one of listed groups</td></tr>
<tr><td>1</td><td>Puerto Rican</td></tr>
<tr><td>2</td><td>Mexican</td></tr>
<tr><td>3</td><td>Cuban</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Field Name</th><th>Type</th><th>Size</th><th>Begin</th><th>End</th><th>Comments</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td><table><tr><td>4</td><td>Other Hispanic</td></tr><tr><td>5</td><td>Arab Chaldean</td></tr></table></td></tr>
<tr><td>Marital Status</td><td>Text</td><td>1</td><td>75</td><td>75</td><td><table><tr><th>Code</th><th>Description</th></tr><tr><td>1</td><td>Never Married</td></tr><tr><td>2</td><td>Married/Cohabiting</td></tr><tr><td>3</td><td>Widowed</td></tr><tr><td>4</td><td>Divorced</td></tr><tr><td>5</td><td>Separated</td></tr></table></td></tr>
<tr><td>Military Status</td><td>Text</td><td>1</td><td>76</td><td>76</td><td>1 = yes
2 = no</td></tr>
<tr><td>Education</td><td>Text</td><td>2</td><td>77</td><td>78</td><td>00 to 25 number of years of education (e.g., 4 years of college = 16)</td></tr>
<tr><td>Currently in Training / Education</td><td>Text</td><td>1</td><td>79</td><td>79</td><td>4 = in training program
6 = in special education
7 = is attending undergraduate college
0 = not applicable</td></tr>
<tr><td>Employment Status</td><td>Text</td><td>1</td><td>80</td><td>80</td><td><table><tr><th>Code</th><th>Description</th></tr><tr><td>1</td><td>Employed, full time</td></tr><tr><td>2</td><td>Employed, part time</td></tr><tr><td>3</td><td>Unemployed - laid off, fired, seasonal, actively sought work in last 30 days</td></tr><tr><td>4</td><td>Not in competitive labor force - includes homemaker, student age 18 and over, day program participant, resident or inmate of an institution (includes nursing home)</td></tr><tr><td>6</td><td>Retired from work</td></tr><tr><td>8</td><td>Not applicable to the person (e.g., child under age 18)</td></tr></table></td></tr>
<tr><td>Primary Substance</td><td>Text</td><td>2</td><td>81</td><td>82</td><td><table><tr><th>Code</th><th>Description</th></tr><tr><td>00</td><td>None</td></tr><tr><td>10</td><td>Alcohol</td></tr><tr><td>20</td><td>Heroin</td></tr><tr><td>21</td><td>Methadone (illicit)</td></tr><tr><td>22</td><td>Other opiates or synthetics</td></tr><tr><td>30</td><td>Barbituates</td></tr><tr><td>31</td><td>Other sedatives or hypnotics</td></tr><tr><td>32</td><td>Other tranquilizers</td></tr><tr><td>33</td><td>Benzodiazepines</td></tr><tr><td>34</td><td>GHB, GBL</td></tr><tr><td>41</td><td>Cocaine</td></tr><tr><td>42</td><td>Crack Cocaine</td></tr><tr><td>43</td><td>Methamphetamines</td></tr><tr><td>44</td><td>Other amphetamines</td></tr></table></td></tr>
</table>

<table>
<tr><th>Field Name</th><th>Type</th><th>Size</th><th>Begin</th><th>End</th><th>Comments</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>
<table>
<tr><td>45</td><td>Methcathinone</td></tr>
<tr><td>50</td><td>Hallucinogens</td></tr>
<tr><td>51</td><td>PCP</td></tr>
<tr><td>52</td><td>Marijuana/hashish</td></tr>
<tr><td>53</td><td>Ecstasy (MDMA, MDA)</td></tr>
<tr><td>54</td><td>Ketamine</td></tr>
<tr><td>60</td><td>Inhalants</td></tr>
<tr><td>61</td><td>Antidepressants</td></tr>
<tr><td>70</td><td>Over-the-counter</td></tr>
<tr><td>72</td><td>Steroids</td></tr>
<tr><td>81</td><td>Talwin and PBZ</td></tr>
<tr><td>91</td><td>Other</td></tr>
</table>
</td></tr>
<tr><td>Primary Route</td><td>Text</td><td>1</td><td>83</td><td>83</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>0</td><td>Not applicable (drug code was “none”)</td></tr>
<tr><td>1</td><td>Oral</td></tr>
<tr><td>2</td><td>Smoking</td></tr>
<tr><td>3</td><td>Inhalation/intranasal (“snorting”)</td></tr>
<tr><td>4</td><td>Injection</td></tr>
<tr><td>5</td><td>Other</td></tr>
</table>
</td></tr>
<tr><td>Primary Age at First Use</td><td>Text</td><td>2</td><td>84</td><td>85</td><td>2 character age
98 = not applicable (drug code was “none”)</td></tr>
<tr><td>Primary Frequency of Use</td><td>Text</td><td>2</td><td>86</td><td>87</td><td>Number of days drug used in last 30 days
2 characters
00 = not used
30 = used daily
98 = not applicable (drug code was “none”)</td></tr>
<tr><td>Primary Initial Prescription</td><td>Text</td><td>1</td><td>88</td><td>88</td><td>Initially a prescription
0 = not applicable (drug code was “none”)
1 = yes
2 = no</td></tr>
<tr><td>Secondary Substance</td><td>Text</td><td>2</td><td>89</td><td>90</td><td>For list of values, reference Primary Substance</td></tr>
<tr><td>Secondary Route</td><td>Text</td><td>1</td><td>91</td><td>91</td><td>For list of values, reference Primary Route</td></tr>
<tr><td>Secondary Age at First Use</td><td>Text</td><td>2</td><td>92</td><td>93</td><td>2 character age
98 = not applicable (drug code was “none”)</td></tr>
<tr><td>Secondary Frequency of Use</td><td>Text</td><td>2</td><td>94</td><td>95</td><td>Number of days drug used in last 30 days
2 characters
00 = not used
30 = used daily
98 = not applicable (drug code was “none”)</td></tr>
<tr><td>Secondary Initial Prescription</td><td>Text</td><td>1</td><td>96</td><td>96</td><td>Initially a prescription
0 = not applicable (drug code was “none”)
1 = yes</td></tr>
</table>

Field Name	Type	Size	Begin	End	Comments
					2 = no
Tertiary Substance	Text	2	97	98	For list of values, reference Primary Substance
Tertiary Route	Text	1	99	99	For list of values, reference Primary Route
Tertiary Age at First Use	Text	2	100	101	2 character age 98 = not applicable (drug code was "none")
Tertiary Frequency of Use	Text	2	102	103	Number of days drug used in last 30 days 2 characters 00 = not used 30 = used daily 98 = not applicable (drug code was "none")
Tertiary Initial Prescription	Text	1	104	104	Initially a prescription 0 = not applicable (drug code was "none") 1 = yes 2 = no
Total Annual Income	Number	6	105	110	6 characters, rounded to the nearest whole dollar; no decimal points or commas
Number of Dependants	Text	2	111	112	Number of dependents claimed in determining ability-to-pay
Program Eligibility: Able to pay	Number	1	113	113	1 = yes 2 = no
Program Eligibility: Commercial insurance	Number	1	114	114	1 = yes 2 = no
Program Eligibility: Services contract	Number	1	115	115	1 = yes 2 = no
Program Eligibility: Medicare	Number	1	116	116	1 = yes 2 = no
Program Eligibility: Medicaid	Number	1	117	117	1 = yes 2 = no
Program Eligibility: Workers Compensation	Number	1	118	118	1 = yes 2 = no
Program Eligibility: other public sources	Number	1	119	119	1 = yes 2 = no
Program Eligibility: CA resources	Number	1	120	120	1 = yes 2 = no
Program Eligibility: State Medical Plan	Number	1	121	121	1 = yes 2 = no
Program Eligibility: MI Child	Number	1	122	122	1 = yes 2 = no
Program Eligibility: Medicaid Children' Waiver	Number	1	123	123	1 = yes 2 = no
Program Eligibility: other Program Eligibility not listed	Number	1	124	124	1 = yes 2 = no

<table>
<tr><th>Field Name</th><th>Type</th><th>Size</th><th>Begin</th><th>End</th><th>Comments</th></tr>
<tr><td>above</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Correctional Status</td><td>Text</td><td>2</td><td>125</td><td>126</td><td><table><tr><th>Code</th><th>Description</th></tr><tr><td>00</td><td>No status with corrections system</td></tr><tr><td>01</td><td>In prison</td></tr><tr><td>02</td><td>In jail</td></tr><tr><td>03</td><td>Paroled from prison</td></tr><tr><td>04</td><td>Probation from jail</td></tr><tr><td>05</td><td>Juvenile detention center</td></tr><tr><td>06</td><td>Court supervision</td></tr><tr><td>07</td><td>Interacted with but not under jurisdiction of law enforcement program</td></tr><tr><td>08</td><td>Awaiting trial</td></tr><tr><td>09</td><td>Awaiting sentencing</td></tr><tr><td>10</td><td>Refused to provide information</td></tr><tr><td>98</td><td>Unknown</td></tr></table></td></tr>
<tr><td>Total Arrests - 6 months</td><td>Number</td><td>2</td><td>127</td><td>128</td><td>00 if no arrests</td></tr>
<tr><td>Arrests - Possession/Sales - 6 Months</td><td>Number</td><td>2</td><td>129</td><td>130</td><td>00 if no arrests</td></tr>
<tr><td>Arrests - DUI/DWIl - 6 months</td><td>Number</td><td>2</td><td>131</td><td>132</td><td>00 if no arrests</td></tr>
<tr><td>Total Arrests - 5 years</td><td>Number</td><td>2</td><td>133</td><td>134</td><td>00 if no arrests</td></tr>
<tr><td>Arrests - Possession/Sales - 5 years</td><td>Number</td><td>2</td><td>135</td><td>136</td><td>00 if no arrests</td></tr>
<tr><td>Arrests - DUI/DWI - 5 years</td><td>Number</td><td>2</td><td>137</td><td>138</td><td>00 if no arrests</td></tr>
<tr><td>Living Arrangement</td><td>Text</td><td>1</td><td>139</td><td>139</td><td>1 = independent
2 = dependent
3 = homeless</td></tr>
<tr><td>Methadone Part of Treatment</td><td>Text</td><td>1</td><td>140</td><td>140</td><td>1 = yes
2 = no</td></tr>
<tr><td>Primary Diagnosis</td><td>Text</td><td>6</td><td>141</td><td>146</td><td>Reference Appendix D.4 SA Diagnosis Codes for a list of the valid values</td></tr>
<tr><td>Secondary Diagnosis</td><td>Text</td><td>6</td><td>147</td><td>152</td><td>Secondary Diagnosis may not be the same as Primary Diagnosis</td></tr>
<tr><td>Pregnant</td><td>Text</td><td>1</td><td>153</td><td>153</td><td>1 = yes
2 = no</td></tr>
<tr><td>Other Factor 1</td><td>Text</td><td>1</td><td>154</td><td>154</td><td><table><tr><th>Code</th><th>Description</th></tr><tr><td>0</td><td>None</td></tr><tr><td>2</td><td>Adult child</td></tr><tr><td>3</td><td>Significant other</td></tr><tr><td>4</td><td>Hearing impaired</td></tr></table></td></tr>
</table>

Field Name	Type	Size	Begin	End	Comments
					5 Visually impaired 6 Head injury 7 Developmentally disabled 8 Mobility impaired 9 Mental illness
Other Factor 2	Text	1	155	155	For list of values, reference Other Factor 1
Other Factor 3	Text	1	156	156	For list of values, reference Other Factor 1
Time Waiting to Enter Treatment	Number	3	157	159	3 digit number of days
Primary Language Spoken	Alpha	3	160	162	For list of values, reference http://lcweb.loc.gov/standards/iso639-2/langhome.html
Admission Time of Day	Number	4	163	166	24-hour HHMM
Error ID	Number	8	167	174	

D.2.3 SA Admission Trailer Format

Field Name	Type	Size	Begin	End	Comments
Note: Any errors on the HDDR or TRLR record will cause the entire file to reject and be returned to the appropriate submitter via the Data Exchange Gateway (DEG) via the 4823 file.					
EDI TYPE	Text	4	1	4	"TRLR"
EDI APP	Text	2	5	6	"MA"
EDI USER					
EDI USER - prefix	Text	5	7	11	"DCH00" (DCH zero zero)
EDI USER - CA ID	Text	2	12	13	Service Bureau ID
EDI USER - suffix	Text	1	14	14	Blank
EDI CREATION DATE	Text	8	15	22	YYYYMMDD
EDI TRANSFER DATE	Text	8	23	30	YYYYMMDD
EDI TRANSFER TIME	Text	4	31	34	HHMM
EDI FILE NAME	Text	4	35	38	4823
EDI RUN TYPE	Text	1	39	39	"P" for production or "T" for test
EDI BATCH IDENTIFIER	Text	3	40	42	Unique batch identifier assigned by CA
EDI RECORD COUNT	Number	6	43	48	Number of records in a file including the header and trailer
FILLER	Text	126	49	174	

D.3 SA Discharge File Format

D.3.1 SA Discharge Header Format

Field Name	Type	Size	Begin	End	Comments
Note: Any errors on the HDDR or TRLR record will cause the entire file to reject and be returned to the appropriate submitter via the Data Exchange Gateway (DEG) via the 4824 file.					
EDI TYPE	Text	4	1	4	"HDDR"
EDI APP	Text	2	5	6	"MA"
EDI USER					
EDI USER - prefix	Text	5	7	11	"DCH00" (DCH zero zero)
EDI USER - CA ID	Text	2	12	13	Service Bureau ID
EDI USER - suffix	Text	1	14	14	Blank
EDI CREATION DATE	Text	8	15	22	YYYYMMDD
EDI TRANSFER DATE	Text	8	23	30	YYYYMMDD
EDI TRANSFER TIME	Text	4	31	34	HHMM
EDI FILE NAME	Text	4	35	38	4824
EDI RUN TYPE	Text	1	39	39	"P" for production or "T" for test
EDI BATCH IDENTIFIER	Text	3	40	42	Unique batch identifier assigned by CA
FILLER	Text	64	43	106	

D.3.2 SA Discharge Input File Format

Field Name	Type	Size	Begin	End	Comments
Note: A Discharge Record is stored using the following key values: CA Payer ID, License Number, Social Security Number, CA Client ID, Admission Date, Admission Time of Day, Discharge Service Category. Each Discharge Record must have the following unique key values: CA Payer ID, License Number, Social Security Number, CA Client ID, Admission Date, Admission Time of Day.					
Record Type	Text	1	1	1	A=Admission D=Discharge S=SARF X=Transition-out Y=Transition-in
Submission Type	Text	1	2	2	A=Add C=Change D=Delete E=Error

<table>
<tr><th>Field Name</th><th>Type</th><th>Size</th><th>Begin</th><th>End</th><th>Comments</th></tr>
<tr><td>CA Payer ID</td><td>Text</td><td>9</td><td>3</td><td>11</td><td>
<table>
<tr><th>CA Code</th><th>CA Name</th></tr>
<tr><td>174462881</td><td>Bay-Arenac</td></tr>
<tr><td>174459975</td><td>Kalamazoo</td></tr>
<tr><td>174456919</td><td>Macomb</td></tr>
<tr><td>174454709</td><td>Washtenaw</td></tr>
<tr><td>174458216</td><td>Pathways (also known as Eastern Upper Peninsula)</td></tr>
<tr><td>174464053</td><td>Genesee</td></tr>
<tr><td>174455644</td><td>Lakeshore</td></tr>
<tr><td>174458190</td><td>Mid-South</td></tr>
<tr><td>174464080</td><td>Kent</td></tr>
<tr><td>174458207</td><td>Northern</td></tr>
<tr><td>174456937</td><td>Oakland</td></tr>
<tr><td>174454718</td><td>Saginaw</td></tr>
<tr><td>174458243</td><td>SEMCA</td></tr>
<tr><td>174456928</td><td>St. Clair</td></tr>
<tr><td>174463350</td><td>Western Upper Peninsula</td></tr>
<tr><td>174456991</td><td>Detroit</td></tr>
</table>
</td></tr>
<tr><td>License Number</td><td>Text</td><td>6</td><td>12</td><td>17</td><td>DCIS License Number</td></tr>
<tr><td>Social Security Number</td><td>Text</td><td>9</td><td>18</td><td>26</td><td></td></tr>
<tr><td>CA Client Identifier</td><td>Text</td><td>11</td><td>27</td><td>37</td><td></td></tr>
<tr><td>Medicaid Identifier</td><td>Text</td><td>8</td><td>38</td><td>45</td><td>Must be blank if not applicable</td></tr>
<tr><td>Date of Admission</td><td>Text</td><td>8</td><td>46</td><td>53</td><td>CCYYMMDD</td></tr>
<tr><td>Discharge Service Category</td><td>Text</td><td>2</td><td>54</td><td>55</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>11</td><td>Outpatient</td></tr>
<tr><td>21</td><td>Residential detoxification</td></tr>
<tr><td>22</td><td>Residential - short-term (no more than 29 days)</td></tr>
<tr><td>24</td><td>Residential - long-term (30 day or more)</td></tr>
<tr><td>31</td><td>Intensive outpatient</td></tr>
</table>
</td></tr>
<tr><td>Employment Status</td><td>Text</td><td>1</td><td>56</td><td>56</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1</td><td>Employed, full time</td></tr>
<tr><td>2</td><td>Employed, part time</td></tr>
<tr><td>3</td><td>Unemployed - laid off, fired, seasonal, actively sought work in last 30 days</td></tr>
<tr><td>4</td><td>Not in competitive labor force - includes homemaker, student age 18 and over, day program participant, resident or inmate of an institution (includes nursing home)</td></tr>
<tr><td>6</td><td>Retired from work</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Field Name</th><th>Type</th><th>Size</th><th>Begin</th><th>End</th><th>Comments</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td><table><tr><td>8</td><td>Not applicable to the person (e.g., child under age 18)</td></tr></table></td></tr>
<tr><td>PSA Code
Primary Substance</td><td>Text</td><td>2</td><td>57</td><td>58</td><td><table><tr><th>Code</th><th>Description</th></tr><tr><td>00</td><td>None</td></tr><tr><td>10</td><td>Alcohol</td></tr><tr><td>20</td><td>Heroin</td></tr><tr><td>21</td><td>Methadone (illicit)</td></tr><tr><td>22</td><td>Other opiates or synthetics</td></tr><tr><td>30</td><td>Barbituates</td></tr><tr><td>31</td><td>Other sedatives or hypnotics</td></tr><tr><td>32</td><td>Other tranquilizers</td></tr><tr><td>33</td><td>Benzodiazepines</td></tr><tr><td>34</td><td>GHB, GBL</td></tr><tr><td>41</td><td>Cocaine</td></tr><tr><td>42</td><td>Crack Cocaine</td></tr><tr><td>43</td><td>Methamphetamines</td></tr><tr><td>44</td><td>Other amphetamines</td></tr><tr><td>45</td><td>Methcathinone</td></tr><tr><td>50</td><td>Hallucinogens</td></tr><tr><td>51</td><td>PCP</td></tr><tr><td>52</td><td>Marijuana/hashish</td></tr><tr><td>53</td><td>Ecstasy (MDMA, MDA)</td></tr><tr><td>54</td><td>Ketamine</td></tr><tr><td>60</td><td>Inhalants</td></tr><tr><td>61</td><td>Antidepressants</td></tr><tr><td>70</td><td>Over-the-counter</td></tr><tr><td>72</td><td>Steroids</td></tr><tr><td>81</td><td>Talwin and PBZ</td></tr><tr><td>91</td><td>Other</td></tr></table></td></tr>
<tr><td>PSA Route
Primary Route</td><td>Text</td><td>1</td><td>59</td><td>59</td><td><table><tr><th>Code</th><th>Description</th></tr><tr><td>0</td><td>Not applicable (drug code was “none”)</td></tr><tr><td>1</td><td>Oral</td></tr><tr><td>2</td><td>Smoking</td></tr><tr><td>3</td><td>Inhalation/intranasal (“snorting”)</td></tr><tr><td>4</td><td>Injection</td></tr><tr><td>5</td><td>Other</td></tr></table></td></tr>
<tr><td>PSA Frequency of Use
Primary Frequency of Use</td><td>Text</td><td>2</td><td>60</td><td>61</td><td>Number of days drug used in last 30 days
2 characters
00 = not used
30 = used daily
98 = not applicable (drug code was “none”)</td></tr>
<tr><td>SSA Code
Secondary Substance</td><td>Text</td><td>2</td><td>62</td><td>63</td><td>For list of values, reference Primary Substance</td></tr>
</table>

<table>
<tr><th>Field Name</th><th>Type</th><th>Size</th><th>Begin</th><th>End</th><th>Comments</th></tr>
<tr><td>SSA Route
Secondary Route</td><td>Text</td><td>1</td><td>64</td><td>64</td><td>For list of values, reference Primary Route</td></tr>
<tr><td>SSA Frequency of Use
Secondary Frequency of Use</td><td>Text</td><td>2</td><td>65</td><td>66</td><td>Number of days drug used in last 30 days
2 characters
00 = not used
30 = used daily
98 = not applicable (drug code was “none”)</td></tr>
<tr><td>TSA Code
Tertiary Substance</td><td>Text</td><td>2</td><td>67</td><td>68</td><td>For list of values, reference Primary Substance</td></tr>
<tr><td>TSA Route
Tertiary Route</td><td>Text</td><td>1</td><td>69</td><td>69</td><td>For list of values, reference Primary Route</td></tr>
<tr><td>TSA Frequency of Use
Tertiary Frequency of Use</td><td>Text</td><td>2</td><td>70</td><td>71</td><td>Number of days drug used in last 30 days
2 characters
00 = not used
30 = used daily
98 = not applicable (drug code was “none”)</td></tr>
<tr><td>Correctional Status</td><td>Text</td><td>2</td><td>72</td><td>73</td><td><table><tr><th>Code</th><th>Description</th></tr><tr><td>00</td><td>No status with corrections system</td></tr><tr><td>01</td><td>In prison</td></tr><tr><td>02</td><td>In jail</td></tr><tr><td>03</td><td>Paroled from prison</td></tr><tr><td>04</td><td>Probation from jail</td></tr><tr><td>05</td><td>Juvenile detention center</td></tr><tr><td>06</td><td>Court supervision</td></tr><tr><td>07</td><td>Interacted with but not under jurisdiction of law enforcement program</td></tr><tr><td>08</td><td>Awaiting trial</td></tr><tr><td>09</td><td>Awaiting sentencing</td></tr><tr><td>10</td><td>Refused to provide information</td></tr><tr><td>98</td><td>Unknown</td></tr></table></td></tr>
<tr><td>Total Arrests - 6 months</td><td>Number</td><td>2</td><td>74</td><td>75</td><td>00 if no arrests</td></tr>
<tr><td>Arrests - Possession/Sales - 6 Months</td><td>Number</td><td>2</td><td>76</td><td>77</td><td>00 if no arrests</td></tr>
<tr><td>Arrests - DUI/DWIl - 6 months</td><td>Number</td><td>2</td><td>78</td><td>79</td><td>00 if no arrests</td></tr>
<tr><td>Living Arrangement</td><td>Text</td><td>1</td><td>80</td><td>80</td><td>1 = independent
2 = dependent
3 = homeless</td></tr>
<tr><td>Date of Discharge</td><td>Text</td><td>8</td><td>81</td><td>88</td><td>CCYYMMDD</td></tr>
<tr><td>Discharge Reason</td><td>Text</td><td>2</td><td>89</td><td>90</td><td><table><tr><th>Code</th><th>Description</th></tr><tr><td>01</td><td>Completed treatment</td></tr><tr><td>02</td><td>Left against staff advice</td></tr><tr><td>03</td><td>In jail</td></tr></table></td></tr>
</table>

Field Name	Type	Size	Begin	End	Comments
					04 Staff decision for rules violations 05 Death 06 Continuing in treatment - transfer 07 Mutual staff/client decision 08 Early jail release 09 Client relocated 10 Program closed/merged 11 Other
Admission Time of Day	Number	4	91	94	24-hour HHMM
Discharge Time of Day	Number	4	95	98	24-hour HHMM
Error ID	Number	8	99	106	

D.3.3 SA Discharge Trailer Format

Field Name	Type	Size	Begin	End	Comments
Note: Any errors on the HDDR or TRLR record will cause the entire file to reject and be returned to the appropriate submitter via the Data Exchange Gateway (DEG) via the 4824 file.					
EDI TYPE	Text	4	1	4	"TRLR"
EDI APP	Text	2	5	6	"MA"
EDI USER					
EDI USER - prefix	Text	5	7	11	"DCH00" (DCH zero zero)
EDI USER - CA ID	Text	2	12	13	Service Bureau ID
EDI USER - suffix	Text	1	14	14	Blank
EDI CREATION DATE	Text	8	15	22	YYYYMMDD
EDI TRANSFER DATE	Text	8	23	30	YYYYMMDD
EDI TRANSFER TIME	Text	4	31	34	HHMM
EDI FILE NAME	Text	4	35	38	4824
EDI RUN TYPE	Text	1	39	39	"P" for production or "T" for test
EDI BATCH IDENTIFIER	Text	3	40	42	Unique batch identifier assigned by CA
EDI RECORD COUNT	Number	6	43	48	Number of records in a file including the header and trailer
FILLER	Text	58	49	106	

D.4 SA Diagnosis Codes

DRUG CODE	DRUG	DIAGNOSIS CODE	DIAGNOSIS
00	None	000.00	N/A
10	Alcohol		Alcohol
		305.00	abuse
		291.10	amnestic disorder
		303.90	dependence
		291.30	hallucinosis
		291.40	idiosyncratic intoxication
		303.00	intoxication
		291.00	withdrawal delirium
		291.20	Dementia associated with alcoholism
		291.80	Uncomplicated alcohol withdrawal
20	Heroin		Opioid
21	Methadone (non-Rx)	305.50	abuse/intoxication
22	Other opiates/synthetics	304.00	dependence
		292.00	withdrawal
30	Barbiturates		Sedative, hypnotic, or anxiolytic
31	Other sedatives/hypnotics	305.40	abuse/intoxication
32	Other tranquilizers	292.83	amnestic disorder
33	Benzodiazepine	304.10	dependence
34	GHB, GBL	292.00	withdrawal delirium
41	Cocaine		Cocaine
42	Crack Cocaine	305.60	abuse/intoxication
		292.81	delirium
		292.11	delusional disorder
		304.20	dependence
		292.00	withdrawal
43	Methamphetamines		Amphetamine or similarly acting sympathomimetic
44	Other amphetamines	305.70	abuse/intoxication
45	Methcathinone ("cat")	292.11	delusional disorder
		292.81	delirium
		304.40	dependence
		292.00	withdrawal
50	Hallucinogens		Hallucinogen
		305.30	abuse/hallucinosis
		292.11	delusional disorder
		305.30	dependence
		292.84	mood disorder
		292.89	Posthallucinogen perception disorder
51	PCP		Phencyclidine (PCP) or similarly acting arylcyclohexylamine:
		305.90	abuse/intoxication
		292.81	delirium
		292.11	delusional disorder
		304.50	dependence
		292.84	mood disorder
		292.90	organic mental disorder NOS

DRUG CODE	DRUG	DIAGNOSIS CODE	DIAGNOSIS
53	Ecstasy	305.90	abuse/intoxication
54	Ketamine	292.81	delirium
		292.11	delusional disorder
		304.50	dependence
		292.84	mood disorder
		292.90	organic mental disorder NOS
52	Marijuana/hashish		Cannabis
		305.20	abuse/intoxication
		292.11	delusional disorder
		304.30	dependence
60	Inhalants		Inhalant
		305.90	abuse/intoxication
		304.60	dependence
61	Antidepressants		Other or unspecified psychoactive substance
		305.90	abuse/intoxication
		292.83	amnestic disorder
		292.89	anxiety disorder
		292.81	delirium
		292.11	delusional disorder
		292.82	dementia
		292.12	hallucinosis
		292.84	mood disorder
		292.90	organic mental disorder NOS
		292.89	personality disorder
		292.00	withdrawal
		304.90	Psychoactive substance dependence NOS
70	Over-the-Counter	305.90	Caffeine intoxication
72	Steroids	305.90	Other or unspecified psychoactive substance
			abuse/intoxication
		304.90	Psychoactive substance dependence NOS
81	Talwin and PBZ		Opioid
		305.50	abuse/intoxication
		304.00	dependence
		292.00	withdrawal
91	Other		Nicotine
		305.10	dependence
		292.00	withdrawal
			Other or unspecified psychoactive substance
		305.90	abuse/intoxication
		292.83	amnestic disorder
		292.89	anxiety disorder
		292.81	delirium
		292.11	delusional disorder
		292.82	dementia
		292.12	hallucinosis
		292.84	mood disorder
		292.90	organic mental disorder NOS
		292.89	personality disorder

DRUG CODE	DRUG	DIAGNOSIS CODE	DIAGNOSIS
		292.00 304.90	withdrawal Psychoactive substance dependence NOS
Polysubstance (Must specify at least a primary and a secondary drug from list above and must be dependent on both)		304.80	Polysubstance dependence

D.5 SA County Codes

Code	County
00	Out of State (Out of state other than those listed in codes 85-89)
01	Alcona
02	Alger
03	Allegan
04	Alpena
05	Antrim
06	Arenac
07	Baraga
08	Barry
09	Bay
10	Benzie
11	Berrien
12	Branch
13	Calhoun
14	Cass
15	Charlevoix
16	Cheboygan
17	Chippewa
18	Clare
19	Clinton
20	Crawford
21	Delta
22	Dickinson
23	Eaton
24	Emmet
25	Genesee
26	Gladwin
27	Gogebic
28	Grand Traverse
29	Gratiot
30	Hillsdale
31	Houghton

Code	County
46	Lenawee
47	Livingston
48	Luce
49	Mackinaw
50	Macomb
51	Manistee
52	Marquette
53	Mason
54	Mecosta
55	Menominee
56	Midland
57	Missaukee
58	Monroe
59	Montcalm
60	Montmorency
61	Muskegon
62	Newaygo
63	Oakland
64	Oceana
65	Ogemaw
66	Ontonagon
67	Osceola
68	Oscoda
69	Otsego
70	Ottawa
71	Presque Isle
72	Roscommon
73	Saginaw
74	St. Clair
75	St. Joseph
76	Sanilac
77	Schoolcraft
78	Shiawassee

Code	County
32	Huron
33	Ingham
34	Ionia
35	Iosco
36	Iron
37	Isabella
38	Jackson
39	Kalamazoo
40	Kalkaska
41	Kent
42	Keweenaw
43	Lake
44	Lapeer
45	Leelanau

Code	County
79	Tuscola
80	Van Buren
81	Washtenaw
82	Wayne (excluding city of Detroit)
83	Wexford
84	City of Detroit
85	Wisconsin
86	Indiana
87	Ohio
88	Illinois
89	Canada
96	Homeless
97	Unknown

D.6 SA Business Rules

BUSINESS RULE CONSIDERATIONS		
System: Substance Abuse Treatment (QI)	Request Numbers:	Date: 01-14-03
I. Static Data Rules – Rules that should always apply to the data.		
IA. Field/Attribute Rules – Rules that define allowed values for fields/attributes.		
IA1. Standard Format. **1. All date field formats are YYYYMMDD.** **2. SOCIAL SECURITY NUMBER format is 999999999.** **3. LICENSE NUMBER format is 999999.** **4. MEDICAID ID format is 99999999.** **5. CA PAYER ID format is 17XXXXXXX.** **6. All YES/NO fields must have 1=YES and 2=NO.** **7. All DIAGNOSTIC CODE formats are 999.99** **8. All multiple digit fields must have leading zeros and be right justified if the values are less than the full length (e.g., 01 in 2 digit field).** **9. Date fields cannot be blank.** **10. CA PAYER ID, LICENSE NUMBER, CA CLIENT ID, and SERVICE CATEGORY cannot be blank.** **11. DISCHARGE REASON cannot be blank.** **12. COUNTY, SEX, RACE, and PRIMARY SUBSTANCE OF ABUSE cannot be blank.** **13. All S4823 (Admission) records must have 174 columns in length.** **14. All S4824 (Discharge)records must have 106 columns in length.** **15. All S4825 (SARF) records must have 152 columns in length.** **16. All time field formats are HHMM (24-hour).**		
IA2. Non Standard Format. NONE		

BUSINESS RULE CONSIDERATIONS

System: Substance Abuse Treatment (QI)	Request Numbers:	Date: 01-14-03

IA3. Domain

1. CA PAYER ID has allowed values of 17 followed by 7 letters or numbers.
2. SERVICE CATEGORY has values of 11, 21, 22, 24, 31, 51, 52.
3. REFERRAL SOURCE has values of 01, 05, 06, 09, 10, 13, 14, 18, 19, 29-49, 90.
4. COUNTY OF RESIDENCE has values of 01-89, 96, 97, 00.
5. RACE has values 1-6, 8, 9, 0.
6. ETHNICITY has values 0-5.
7. MARITAL STATUS has values 1-5.
8. CURRENTLY IN TRAINING OR EDUCATION has values 4, 6, 7 or 0.
9. EMPLOYMENT STATUS has values of 1-4, 6, 8.
10. SUBSTANCE OF ABUSE has values of 00, 10, 20-22, 30-34, 41-45, 50-54, 60, 61, 70, 72, 81, 91.
11. ROUTE OF ADMINISTRATION has values of 0-5.
12. FREQUENCY OF USE has values of 00-30 or 98.
13. INITIALLY PRESCRIPTION has values of 0-2.
14. CORRECTION RELATED STATUS has values of 00-10 or 98
15. LIVING ARRANGEMENT has values of 1-3.
16. DIAGNOSTIC CODE has values of 000.00-999.99.
17. OTHER FACTORS have values of 0, 2-9.
18. DISCHARGE REASON has values of 01-11.
19. RECORD TYPE has values of 'A', 'D', 'S', 'X' (transition-out), 'Y' (transition-in).
20. SUBMISSION TYPE has values of 'A', 'C', 'D', 'E'.
21. ADMISSION TYPE has values of 1, 2.
22. NUMBER OF PRIOR TREATMENTS has values of 00-96.
23. SEX has values of 1,2.
24. EDUCATION has values of 00-25.
25. AGE AT FIRST USE has values of 00-96, or 98.
26. TIME WAITING TO ENTER TREATMENT has values of 000-999.
27. NUMBER OF DEPENDENTS has values of 00-99.
28. CODEPENDENT has values of 1, 2.
29. MILITARY STATUS has values of 1, 2.
30. METHADONE has values of 1, 2.
31. PREGNANT has values of 1, 2.

BUSINESS RULE CONSIDERATIONS

System: Substance Abuse Treatment (QI)	Request Numbers:	Date: 01-14-03

IA4. Required Field/Attributes

1. For treatment admissions, required fields are RECORD TYPE, SUBMISSION TYPE, CA PAYER ID, LICENSE NUMBER, CA CLIENT ID, ADMISSION TYPE, CODEPENDENT, DATE OF ADMISSION, SERVICE CATEGORY, NUMBER OF PRIOR TREATMENTS, REFERRAL SOURCE, COUNTY OF RESIDENCE, DATE OF BIRTH, SEX, RACE, ETHNICITY, MARITAL STATUS, MILITARY STATUS, EDUCATION, CURRENTLY IN TRAINING/EDUCATION, EMPLOYMENT STATUS, SUBSTANCE ABUSE HISTORY, ROUTE OF ADMINISTRATION, AGE AT FIRST USE, FREQUENCY OF USE, INITIALLY A PRESCRIPTION, PROGRAM ELIGIBILITIES, CORRECTIONS RELATED STATUS, ARREST HISTORY FOR 6 MONTHS AND 5 YEARS, LIVING ARRANGEMENT, METHADONE, PRIMARY and SECONDARY DIAGNOSIS, PREGNANT, TIME WAITING TO ENTER TREATMENT, PRIMARY LANGUAGE SPOKEN, ADMISSION TIME OF DAY.
2. For treatment discharges, required fields are RECORD TYPE, SUBMISSION TYPE, CA PAYER ID, LICENSE NUMBER, CA CLIENT ID, DATE OF ADMISSION, DISCHARGE SERVICE CATEGORY, EMPLOYMENT STATUS, SUBSTANCE ABUSE HISTORY, ROUTE OF ADMINISTRATION, FREQUENCY OF USE, CORRECTIONS RELATED STATUS, ARREST HISTORY FOR 6 MONTHS, LIVING ARRANGEMENT, DATE OF DISCHARGE, DISCHARGE REASON, ADMISSION TIME OF DAY, DISCHARGE TIME OF DAY.
3. For SARF, required fields are RECORD TYPE, SUBMISSION TYPE, CA PAYER ID, LICENSE NUMBER, CA CLIENT ID, ADMISSION TYPE, CODEPENDENT, DATE OF ADMISSION, SERVICE CATEGORY, NUMBER OF PRIOR TREATMENTS, REFERRAL SOURCE, COUNTY OF RESIDENCE, DATE OF BIRTH, SEX, RACE, ETHNICITY, MARITAL STATUS, MILITARY STATUS, EDUCATION, CURRENTLY IN TRAINING/EDUCATION, EMPLOYMENT STATUS, SUBSTANCE ABUSE HISTORY, ROUTE OF ADMINISTRATION, AGE AT FIRST USE, FREQUENCY OF USE, INITIALLY A PRESCRIPTION, PROGRAM ELIGIBILITIES, CORRECTIONS RELATED STATUS, ARREST HISTORY FOR 6 MONTHS AND 5 YEARS, LIVING ARRANGEMENT, PREGNANT, PRIMARY LANGUAGE SPOKEN.

IA5. Other Fields/Attributes

1. All ADMISSION, DISCHARGE, and BIRTH DATES must be less than the system date.

BUSINESS RULE CONSIDERATIONS

System: Substance Abuse Treatment (QI)	Request Numbers:	Date: 01-14-03

IB. Multiple Field/Attribute Rules – Rules that define allowed values for fields/attributes that depend on the value of other fields/attributes of the same table/dataset/entity.

1. Client's ADMISSIONS and DISCHARGE DATES must be greater than DATE OF BIRTH.
2. AGE AT FIRST USE must be less than or equal to current age.
3. ADMISSION DATE_TIME must be less than DISCHARGE DATE_TIME.
4. TOTAL ARRESTS must be greater than or equal to DRUG or DUI/DWI ARRESTS.
5. TOTAL ARRESTS must be greater than or equal to the sum of DRUG and DUI//DWI arrests.
6. TOTAL ARRESTS FOR 5 YEARS must be greater than or equal to TOTAL ARRESTS FOR 6 MONTHS.
7. DRUG ARRESTS FOR 5 YEARS must be greater than or equal to DRUG ARRESTS FOR 6 MONTHS.
8. DUI/DWI ARRESTS FOR 5 YEARS must be greater than or equal to DUI/DWI ARRESTS FOR 6 MONTHS.
9. TOTAL ARRESTS FOR 5 YEARS must be greater than or equal to DRUG or DUI/DWI ARRESTS FOR 6 MONTHS.
10. TOTAL ARRESTS FOR 5 YEARS must be greater than or equal to the sum of DRUG or DUI/DWI ARRESTS FOR 6 MONTHS.
11. OTHER FACTOR 2 cannot be the same as OTHER FACTOR 3.
12. OTHER FACTOR 1 cannot be the same as OTHER FACTOR 2 or OTHER FACTOR 3

IC. Table/Dataset/Entity Rules – Rules that define allowable values for the fields/attributes that are base on values of other occurrences of the same table/dataset/entity.

BUSINESS RULE CONSIDERATIONS

System: Substance Abuse Treatment (QI)	Request Numbers:	Date: 01-14-03

IC1. Unique Identifier

1. Unique client identifier consists of CA PAYER ID and SOCIAL SECURITY NUMBER and CA CLIENT ID.

2. Admission record unique identifier consists of CA PAYER ID, LICENSE NUMBER, SOCIAL SECURITY NUMBER, CA CLIENT ID, ADMISSION DATE_TIME, ADMISSION SERVICE CATEGORY.

3. Discharge record unique identifier consists of CA PAYER ID, LICENSE NUMBER, SOCIAL SECURITY NUMBER, CA CLIENT ID, ADMISSION DATE_TIME, DISCHARGE SERVICE CATEGORY.

4. SARF record unique identifier consists of CA PAYER ID, LICENSE NUMBER, SOCIAL SECURITY NUMBER, CA CLIENT ID, ADMISSION DATE, SERVICE CATEGORY.

IC2. Other Table/Dataset/Entity

NONE

ID. Multiple Table/Dataset/Entity Rules – Rules that define allowable values that are based on occurrences of other tables/datasets/entities. They also define relationship rules.

ID1. Relationship Rules.

1. SUBSTANCE OF ABUSE codes of 10, 20, 41, 42, 45, 50, 51, 52 must have INITIALLY PRESCRIPTION=0 or 2.
2. If the PRIMARY SUBSTANCE OF ABUSE code equals 00 and CODEPENDENT =2 (no), one of the OTHER FACTORS must have codependent or significant other (codes 2 and 3).
3. All drugs' ROUTE OF ADMINISTRATION must match the corresponding SUBSTANCE OF ABUSE listed in the coding structure.
4. If PREGNANT equals 1 (YES), SEX must be 2.
5. If MEDICAID ELIGIBILITY has an entry, valid MEDICAID ID must exist.
6. If EMPLOYMENT STATUS is 1 or 2, TOTAL INCOME must be greater than 0.
7. If COUNTY OF RESIDENCE is 96, LIVING ARRANGEMENT must be 3.
8. For Admission and Discharge records, SERVICE CATEGORY must be 11, 21, 22, 24, or 31.
9. For SARF records, SERVICE CATEGORY must be 51 or 52.
10. If RECORD TYPE = 'E', ERROR ID must have a valid entry.

BUSINESS RULE CONSIDERATIONS

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ID2. Restricted Relationships

1. FREQUENCY OF USE at discharge cannot be greater than the number of days between Admission and Discharge.
2. SECONDARY SUBSTANCE OF ABUSE cannot be the same as PRIMARY SUBSTANCE OF ABUSE.
3. TERTIARY SUBSTANCE OF ABUSE cannot be the same as PRIMARY SUBSTANCE OF ABUSE.
4. TERTIARY SUBSTANCE OF ABUSE cannot be the same as SECONDARY SUBSTANCE OF ABUSE.
5. To have METHADONE part of treatment=1 (YES), provider LICENSE should offer methadone treatment.
6. SUBSTANCE OF ABUSE code of 00 must have DIAGNOSIS code of 000.00.
7. If PRIMARY, SECONDARY, or TERTIARY SUBSTANCE OF ABUSE is 00, corresponding FREQUENCY OF USE must be 98; ROUTE OF ADMINISTRATION must be 0; AGE AT FIRST USE must be 98.
8. If PRIMARY SUBSTANCE OF ABUSE is 00, SECONDARY SUBSTANCE OF ABUSE must be 00.
9. If SECONDARY SUBSTANCE OF ABUSE is 00, TERTIARY SUBSTANCE OF ABUSE must be 00.
10. PRIMARY DIAGNOSIS must be one of the following: 000.00, 291.00, 291.10, 291.20, 291.30, 291.40, 291.80, 292.00, 292.11, 292.12, 292.81, 292.82, 292.83, 292.84, 292.89, 292.90, 303.00, 303.90, 304.00, 304.10, 304.20, 304.30, 304.40, 304.50, 304.60, 304.80, 304.90, 305.00, 305.10, 305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90.
11. PRIMARY LANGUAGE SPOKEN must be in the list of values at http://lcweb.loc.gov/standards/iso639-2/langhome.html.

ID3. Other Multiple Table/Dataset/Entity Rules

NONE

II. Data Operation Rules – Rules describing conditions on which a table/dataset/entity occurrence can be created or deleted, a field/attribute value or relationship created or modified.

IIA. Create Rules.

NONE

BUSINESS RULE CONSIDERATIONS

System: Substance Abuse Treatment (QI)	Request Numbers:	Date: 01-14-03

IIB. Update Rules

1. If SUBMISSION TYPE is 'A', there cannot be any record matching unique identifiers.
2. If SUBMISSION TYPE is 'C', there must be a record matching unique identifiers. Also, if record type is TRANSITION OUT (see #6 below) or TRANSITION IN (see #7 below), matching record must have Federal Submission Date = 1-1-9001. Other record types (ADMISSION, DISCHARGE, SARF) must have Federal Submission Date not = 1-1-9001.
3. If SUBMISSION TYPE is 'D', there must be a record matching unique identifiers. Also, if record type is TRANSITION OUT (see #6 below) or TRANSITION IN (see #7 below), matching record must have Federal Submission Date = 1-1-9001. Other record types (ADMISSION, DISCHARGE, SARF) must have Federal Submission Date not = 1-1-9001.
4. Each DISCHARGE record must have a matching ADMISSION record with regard to the unique identifiers.
5. See Appendix A for additional Update Rules.
6. TRANSITION OUT transaction:
    a) has a RECORD TYPE = "X".
    b) will be edited as a DISCHARGE.
    c) will only be allowed if the "transition window" is open.
    d) must be created with a FEDERAL SUBMISSION DATE of 1-1-9001.
    e) will not be included in SPSS or Federal Extracts.
7. TRANSITION IN transaction:
    a) has a RECORD TYPE = "Y".
    b) will be edited as an ADMISSION.
    c) will only be allowed if the "transition window" is open.
    d) must be created with a FEDERAL SUBMISSION DATE of 1-1-9001.
    e) will not be included in SPSS or Federal Extracts.

IIB1. Transferable Relationships

NONE

IIB2. Field/Attribute Transition

NONE

BUSINESS RULE CONSIDERATIONS

System: Substance Abuse Treatment (QI)	Request Numbers:	Date: 01-14-03

IIB3. Other Update Rule.

NONE

IIC. Delete Rules – Rules that defines the conditions for the deletion of a table/dataset/entity or relationship.

IIC1. Relationship Delete.

NONE

IIC2. Other Delete Rules

NONE

III. Change Event Rules - A rule that defines an automated action that must take place after a data state change.

NONE

IV. Authorization Rules – Rules that define conditions that users must meet to be authorized to perform certain business functions or operate on specific data.

IVA. Function Access

NONE

IVB. Row

NONE

IVC. Column Access

NONE

BUSINESS RULE CONSIDERATIONS

System: Substance Abuse Treatment (QI)	Request Numbers:	Date: 01-14-03

Appendix A (Synchronization Edits).

Overriding Rules:

(1) User cannot change unique ID fields. Only delete and add are allowed.

(2) ADMISSION must have ADM DATE_TIME > 6-30-1910/23:59.

(3) DISCHARGE must have ADM DATE_TIME and DIS DATE_TIME > 6-30-1910/23:59. ADM DATE_TIME can't be changed (it is also part of the UNIQUE key).

(4) In order for a discharge to match an admission for a given client, the service category and license must match.

I. ADD

1. Admission or Transition In

```
If matching ADMISSION (CA PAYER ID, LICENSE, SSN, CA CLIENT ID, ADM
  DATE_TIME) exists
    Error (matching ADMISSION already exists)
Else
    If other ADMISSION (CA PAYER ID, LICENSE, SSN, CA CLIENT ID) exists
        If client's current status is discharged
            If last DISCHARGE is a TRANSITION OUT
                Error (last DISCHARGE is a TRANSITION OUT)
            Else
                If ADM DATE_TIME > last DIS DATE_TIME
                  Create ADMISSION
                Else  -- ADM DATE_TIME <= last DIS DATE_TIME
                    Error (ADM DATE_TIME invalid for last DIS DATE_TIME)
                Endif
            Endif
          Else
```

BUSINESS RULE CONSIDERATIONS

System: Substance Abuse Treatment (QI)	Request Numbers:	Date: 01-14-03

```
                    Error (current status is admitted status)
                Endif
            Else
                Create ADMISSION
            Endif
        Endif
```

2. Discharge or Transition Out

```
If matching DISCHARGE (CA PAYER ID, LICENSE, SSN, CA CLIENT ID, ADM
 DATE_TIME) exists
    Error (matching DISCHARGE already exists)
Else
     If ADM DATE_TIME in DISCHARGE not = ADM DATE_TIME of open existing
        ADMISSION
         Error (no matching ADMISSION)
   Else
         -- earlier edit has verified DIS DATE_TIME > ADM DATE_TIME
          If matching ADM SERV CAT = DIS SERV CAT
                Create DISCHARGE
            Else
                Error (DIS SERV CAT not = ADM SERV CAT)
            Endif
        Endif
 Endif
```

3. SARF

```
If matching SARF (CA PAYER ID, LICENSE, SSN, CA CLIENT ID, ADM
  DATE, SERV CAT) exists
      Error (matching SARF already exists)
Else
      Create SARF
Endif
```

II. DELETE

1. Admission or Transition In

If matching ADMISSION (CA PAYER ID, LICENSE, SSN, CA CLIENT ID, ADM DATE_TIME, ADM SERV CAT) exists
  If matching DISCHARGE exists
    Error (matching DISCHARGE exists)
  Else
    Delete ADMISSION
  Endif
Else
  Error (no matching ADMISSION to delete)
Endif

2. Discharge or Transition Out

If matching DISCHARGE (CA PAYER ID, LICENSE, SSN, CA CLIENT ID, ADM DATE_TIME, DIS SERV CAT) exists
  If deletion will make 2 consecutive admissions
    Error (2 consecutive admissions)
  Else
    Delete DISCHARGE
  Endif
Else
  Error (no matching DISCHARGE to delete)
Endif

3. SARF

If matching SARF (CA PAYER ID, LICENSE, SSN, CA CLIENT ID, ADM DATE, SERV CAT) exists
  Delete SARF
Else
  Error (no matching SARF to delete)
Endif

III. CHANGE

1. Admission or Transition In

BUSINESS RULE CONSIDERATIONS

System: Substance Abuse Treatment (QI)	Request Numbers:	Date: 01-14-03

If matching ADMISSION (CA PAYER ID, LICENSE, SSN, CA CLIENT ID, ADM DATE_TIME, ADM SERV CAT) exists
Replace exiting one with new ADMISSION
Else
Error (no matching ADMISSION exists)
Endif

2. Discharge or Transition Out

If matching DISCHARGE (CA PAYER ID, LICENSE, SSN, CA CLIENT ID, ADM DATE_TIME, DIS SERV CAT) exists
If new DIS DATE_TIME > old DIS DATE_TIME
If the next ADMISSION exists
If new DIS DATE_TIME >= next ADM DATE_TIME
Error (2 consecutive ADMISSIONS)
Else
Replace existing one with new DISCHARGE
Endif
Else
Replace existing one with new DISCHARGE
Endif
Else
If new DIS DATE_TIME < old DIS DATE_TIME
-- earlier edit has verified DIS DATE_TIME > ADM DATE_TIME
Replace existing one with new DISCHARGE
Else -- new DIS DATE_TIME = old DIS DATE_TIME
Replace existing one with new DISCHARGE
Endif
Endif
Else
Error (no matching DISCHARGE exists)
Endif

4. SARF

If matching SARF (CA PAYER ID, LICENSE, SSN, CA CLIENT ID, ADM DATE, SERV CAT) exists
Replace existing one with new SARF
Else

BUSINESS RULE CONSIDERATIONS		
System: Substance Abuse Treatment (QI)	Request Numbers:	Date: 01-14-03
Error (no matching SARF exists) Endif		

Appendix E Substance Abuse QI Edits

E.1 SA SARF Data Element Edits

The following is the list of SA SARF data element edits listed in the order of the input file format.

Note: All Errors reported in this document will cause the record to be rejected. Every Data Element having a detectable error will produce a copy of the Record in error with appropriate error messages appended. Error records will be stored in the SA Error Master Tables on the Oracle Database. These errors will be returned to the submitter via the 4827 file on the Data Exchange Gateway (DEG).

Error #	Error Description	Field Name
S001	Invalid SARF Record Length - should be 152.	Input File
S098	No matching SARF record - if Submission Type equals C or D, a matching record should exist.	Admission Key CA Code, License Number, Social Security Number, CA Client ID, Admission Date
S099	Duplicate SARF Record - Submission Type equals A and record already exists.	
S002	Invalid SARF Record Type - should be S.	Record Type
S003	Invalid SARF Submission Type - should be A, C, D, E.	Submission Type
S131	Invalid SARF CA Code - not a valid CA Payer Identifier.	CA Code
S132	SARF CA Payer ID and Bureau ID do not Match.	
S005	Invalid SARF License Number - should be 6-digits with no blanks.	License Number
S006	Invalid SARF Social Security Number - should be 9-digits or blank.	Social Security Number
S133	Invalid SARF CA Client Identifier - not permitted to be spaces or null.	CA Client Identifier
S008	Invalid SARF Medicaid ID - should be 8-digits or blank.	Medicaid Identifier
S009	Invalid SARF Admission Type - should be 1 or 2.	Admission Type
S010	Invalid SARF Co-dependent Code - should be 1 or 2.	Co-Dependent
S011	Invalid SARF Date of Admission - should be valid date.	Date of Admission
S069	SARF Date of Admission less than Date of Birth - Date of Admission should be greater than Date of Birth.	
S115	SARF Date of Admission is too old.	
S012	Invalid SARF Service Category - should be 51 or 52.	Service Category
S013	Invalid SARF Number of Prior Treatments - should be 00 - 99.	Number of Prior Treatments
S014	Invalid SARF Referral Source - should be valid code of 01, 05-06, 09-10, 13-14, 18, 29-49, and 90.	Referral Source
S016	Invalid SARF County of Residence - should be 00-89, 96-97.	County of Residence
S017	Invalid SARF Date of Birth - should be valid date and less than current date.	Date of Birth
S018	Invalid SARF Sex - should be 1 or 2.	Sex
S019	Invalid SARF Race - should be 0-6, 8-9.	Race
S020	Invalid SARF Ethnicity - should be 0-5.	Ethnicity
S021	Invalid SARF Marital Status - should be 1-5.	Marital Status

Error #	Error Description	Field Name
S022	Invalid SARF Military Status - should be 1 or 2.	Military Status
S023	Invalid SARF Education - should be 00-25, or blank.	Education
S024	Invalid SARF Currently in Training/Education - should be 0, 4, 6, 7.	Currently in Training/Education
S025	Invalid SARF Employment Status - should be 1-4, 6, 8.	Employment Status
S073	SARF Employed and Total Annual Income zero or blank - if Employment Status equals 1 or 2 then Total Annual Income is to be greater than 0.	
S015	SARF Primary Substance (PSA) and Other Factor do not match - if PSA equals 00 and Co-Dependent equals 2 (no), one of the Other Factors should be 2 or 3.	Primary Substance
S026	Invalid SARF Primary Substance (PSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81, 91.	
S082	SARF Primary Substance of 10, 20, 41, 42, 45, 50-52 and Primary Initial Prescription equals 1 - Primary Substance can't be a prescription.	
S085	SARF Primary Substance and Tertiary Substance are the same - PSA cannot be the same as TSA.	
S087	All 3 SARF Substance values are the same - PSA, SSA, and/or TSA cannot be the same.	
S104	SARF Primary Substance equals 00 and Primary Route not equal 0.	
S107	SARF Primary Substance equals 00 and Primary Age at First Use not equal 98.	
S114	SARF Primary Substance and Secondary Substance are the same - PSA cannot be same as SSA.	
S027	Invalid SARF Primary Route - should be 0-5.	Primary Route
S028	Invalid SARF Primary Age at First Use - should be 00-98.	Primary Age at First Use
S067	SARF Primary Age at First Use greater than current age - Primary Age at First Use should be less than current age.	
S029	Invalid SARF Primary Frequency of Use - should be 00-30 or 98.	Primary Frequency of Use
S092	Invalid SARF Primary Frequency of Use - if PSA equals 00, Primary Frequency of Use must be 98.	
S030	Invalid SARF Primary Initial Prescription - should be 0-2.	Primary Initial Prescription
S031	Invalid SARF Secondary Substance (SSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81, 91.	Secondary Substance
S083	SARF Secondary Substance of 10, 20, 41, 42, 45, 50-52 and Secondary Initial Prescription equals 1 - Secondary Substance can't be a prescription.	
S086	SARF Secondary Substance and Tertiary Substance are the same - SSA cannot be same as TSA.	
S090	Invalid SARF Secondary Substance - if PSA equals 00, SSA should be 00.	
S105	SARF SSA equals 00, Secondary Route must be 0.	
S108	SARF SSA equals 00, Secondary Age at First Use must be 98.	

Error #	Error Description	Field Name
S032	Invalid SARF Secondary Route - should be 0-5.	Secondary Route
S033	Invalid SARF Secondary Age at First Use - should be 00-98.	Secondary Age at First Use
S075	SARF Secondary Age at First Use greater than current age - should be less than current age.	
S034	Invalid SARF Secondary Frequency of Use - Should be 00-30 or 98.	Secondary Frequency of Use
S093	Invalid SARF Secondary Frequency of Use - If SSA equals 00, Secondary Frequency of Use must be 98.	
S035	Invalid SARF Secondary Initial Prescription - Should be 0-2.	Secondary Initial Prescription
S036	Invalid SARF Tertiary Substance (TSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81, 91.	Tertiary Substance
S084	SARF Tertiary Substance of 10, 20, 41, 42, 45, 50-52 and Tertiary Initial Prescription equals 1 - Tertiary Substance can't be a prescription.	
S091	Invalid SARF TSA - if PSA or SSA equals 00, then TSA should be 00.	
S106	SARF TSA equals 00, Tertiary Route must be 0.	
S109	SARF TSA equals 00, Tertiary Age at First Use must be 98.	
S037	Invalid SARF Tertiary Route - should be 0-5.	Tertiary Route
S038	Invalid SARF Tertiary Age at First Use - Should be 00-98.	Tertiary Age at First Use
S088	SARF Tertiary Age at First Use greater than current age - Tertiary Drug at First Use should be less than current age.	
S039	Invalid SARF Tertiary Frequency of Use - Should be 00-30 or 98.	Tertiary Frequency of Use
S094	Invalid SARF Tertiary Frequency of Use - If TSA equals 00, Tertiary Frequency of Use must be 98.	
S040	Invalid SARF Tertiary Initial Prescription - should be 0-2.	Tertiary Initial Prescription
S041	Invalid SARF Total Annual Income - should be 000000 - 999999 or blank.	Total Annual Income
S043	Invalid SARF Program Eligibility: Able to Pay - should be 1 or 2.	Program Eligibility: Able to Pay
S044	Invalid SARF Program Eligibility: Commercial Insurance - should be 1 or 2.	Program Eligibility: Commercial Insurance
S045	Invalid SARF Program Eligibility: Service Contract - should be 1 or 2.	Program Eligibility: Services Contract
S046	Invalid SARF Program Eligibility: Medicare - should be 1 or 2.	Program Eligibility: Medicare
S047	Invalid SARF Program Eligibility: Medicaid - should be 1 or 2.	Program Eligibility: Medicaid
S048	Invalid SARF Program Eligibility: Workers Compensation - should be 1 or 2.	Program Eligibility: Workers Compensation
S049	Invalid SARF Program Eligibility: Other Public Sources - should be 1 or 2.	Program Eligibility: Other Public Sources
S050	Invalid SARF Program Eligibility: CA Resources -should be 1 or 2.	Program Eligibility: CA Resources
S125	Invalid SARF Program Eligibility: State Medical Plan - should be 1 or 2.	Program Eligibility: State Medical Plan

Error #	Error Description	Field Name
S051	Invalid SARF Program Eligibility: MI Child - should be 1 or 2.	Program Eligibility: MI Child
S052	Invalid SARF Program Eligibility: Medicaid Children's Waiver - should be 1 or 2.	Program Eligibility: Medicaid Children's Waiver
S053	Invalid SARF Program Eligibility: Other Payment Eligibility - should be 1 or 2.	Program Eligibility: Other Payment Eligibility Not Listed Above
S054	Invalid SARF Correctional Status - should be 00-10, 98.	Correctional Status
S055	Invalid SARF Total Arrests - 6 months - should be 00-99.	Total Arrests - 6 months
S061	Invalid SARF Total Arrests - 6 months - should be equal or greater than SARF Arrests -Possession/Sales - 6 months plus SARF Arrests - DUI/DWI - 6 months.	
S056	Invalid SARF Arrests - Possession/Sales - 6 months - should be 00-99.	Arrests - Possession/Sales - 6 months
S057	Invalid SARF Arrests - DUI/DWI - 6 months - should be 00-99.	Arrests - DUI/DWI - 6 months
S058	Invalid SARF Total Arrests - 5 years - should be 00-99.	Total Arrests - 5 years
S062	Invalid SARF Total Arrests - 5 years - should be equal or greater than SARF Arrests - Possession/Sales - 5 years plus SARF Arrests - DUI/DWI - 5 years.	
S103	Invalid SARF Total Arrests - 5 years - should be equal or greater than SARF Total Arrests - 6 months.	
S059	Invalid SARF Arrests - Possession/Sales - 5 years - should be 00-99.	Arrests - Possession/Sales - 5 years
S063	Invalid SARF Arrests - Possession/Sales - 5 years - should be equal or greater than SARF Arrests - Possession/Sales - 6 months.	
S060	Invalid SARF Arrests - DUI/DWI - 5 years - should be 00-99.	Arrests - DUI/DWI - 5 years
S064	Invalid SARF Arrests - DUI/DWI s - 5 years - should be equal or greater than SARF Arrests - DUI/DWI - 6 months.	
S065	Invalid SARF Living Arrangement - should be 1-3.	Living Arrangement
S074	SARF Living Arrangement doesn't match County of Residence - if county is 96, then Living Arrangement must be 3 (homeless).	
S066	Invalid SARF Pregnant value - should be 1 or 2.	Pregnant
S070	If SARF pregnant equals 1, then sex must equal 2.	
S078	Invalid SARF Other Factor 1 - should be 0, 2-9, or blank.	Other Factor 1
S079	SARF Other Factor 1 equals Other Factor 2 - Other factor 1 and 2 cannot be the same.	
S080	SARF Other Factor 1 equals Other Factor 3 - Other factor 1 and 3 cannot be the same.	
S127	Invalid SARF Other Factor 2 - should be 0, 2-9, or blank.	Other Factor 2
S081	SARF Other Factor 2 equals Other Factor 3 - Other Factor 2 and 3 cannot be the same.	
S076	SARF Other Factor 2 not zero or blank - if other factor 1 equals 0 or blank, Other Factor 2 should be zero or blank.	
S128	Invalid SARF Other Factor 3 - should be 0, 2-9, or blank.	Other Factor 3

Error #	Error Description	Field Name
S077	SARF Other Factor 3 not zero or blank - if Other Factor 1 or Other Factor 2 equals 0 or blank, Other Factor 3 should be zero or blank.	
S126	Invalid SARF Primary Language Spoken.	Primary Language Spoken
S097	Invalid SARF Error ID - should be valid 8-digit number or blank.	Error ID
S100	Invalid SARF Error ID - should be valid Error ID or blank.	

E.2 SA Admission Data Element Edits

The following is the list of SA Admission data element edits listed in the order of the input file format.

Note: All Errors reported in this document will cause the record to be rejected. Every Data Element having a detectable error will produce a copy of the Record in error with appropriate error messages appended. Error records will be stored in the SA Error Master Tables on the Oracle Database. These errors will be returned to the submitter via the 4827 file on the Data Exchange Gateway (DEG).

Error #	Error Description	Field Name
A001	Invalid Admission Record Length - should be 174.	Input File
A100	Duplicate Admission record - Submission Type equals A and record already exists.	Admission Key CA Code, License Number, Social Security Number, CA Client ID, Admission Date, Admission Time of Day
A122	Admission Submission Type equals A and Date of Admission/Admission Time of Day is equal or prior to prior Discharge Date of Discharge/Discharge Time of Day - cannot add the Admission	
A118	Admission Submission Type equals A and client is already in Admitted Status – cannot add the Admission.	
A138	Admission Submission Type equals C and an Admission record not found - cannot process the change.	
A137	Admission Submission Type equals D and no Admission exits	
A124	Admission Submission Type equals D and Discharge exists with Date of Discharge/Discharge Time of Day greater than Admission Date of Admission/Admission Time of Day - cannot process delete.	
A002	Invalid Admission Record Type - should be A.	Record Type
A127	Transition-in window is not open – Admission record type is Y and transition-in transactions are not currently allowed.	
A128	Transition-in record exists – Regular admission record cannot modify transition-in record.	
A129	Admission record exists – Transition-in record cannot modify regular admission record.	
A130	Admission is not allowed after transition-out has occurred.	
A003	Invalid Admission Submission Type - should be A, C, D, E.	Submission Type
A139	Invalid Admission CA Code - not a valid CA Payer Identifier.	CA Code
A105	Admission CA Payer Identifier and Bureau ID do not match.	
A005	Invalid Admission License number - should be 6-digit.	License Number
A006	Invalid Admission Social Security Number - Should be 9-digit or blank.	Social Security Number

Error #	Error Description	Field Name
A140	Invalid Admission CA Client Identifier - not permitted to be spaces or null.	CA Client Identifier
A008	Invalid Admission Medicaid ID - should be 8-digit or blank.	Medicaid Identifier
A009	Invalid Admission Type - should be 1 or 2.	Admission Type
A010	Invalid Admission Co-Dependent Code - should be 1 or 2.	Co-Dependent
A011	Invalid Admission Date of Admission - should be valid date and less than current date.	Date of Admission
A069	Admission Admit Date less than Birth Date - Date of Admission date should be greater than birth date.	
A106	Admission Date of Admission is too old.	
A012	Invalid Admission Service Category - should be 11, 21, 22, 24, 31.	Service Category
A013	Invalid Admission Number of Prior Treatments - should be 00-96.	Number of Prior Treatments
A014	Invalid Admission Referral Source - should be valid code of 01, 05-06, 09-10, 13-14, 18, 29-49, 90.	Referral Source
A016	Invalid Admission County of Residence - should be 00-89, 96-97.	County of Residence
A017	Invalid Admission Date of Birth - should be valid date and less than current date.	Date of Birth
A018	Invalid Admission Sex - should be 1 or 2.	Sex
A019	Invalid Admission Race - should be 0-6, 8-9.	Race
A020	Invalid Admission Ethnicity - should be 0-5.	Ethnicity
A021	Invalid Admission Marital Status - should be 1-5.	Marital Status
A022	Invalid Admission Military Status - should be 1 or 2.	Military Status
A023	Invalid Admission Education - Should be 00-25.	Education
A024	Invalid Admission Currently in Training/Education - Should be 0, 4, 6-7.	Currently in Training/Education
A025	Invalid Admission Employment Status - should be 1-4, 6, 8.	Employment Status
A073	Admission Employed and Total Annual Income zero or blank - if Employment Status equals 1 or 2 then Total Annual Income is to be greater than 0.	
A015	Admission Primary Substance (PSA) and Other Factor do not match - if PSA equals 00 and Co-Dependent equals 2 (no), one of the Other Factors should be 2-3.	Primary Substance
A026	Invalid Admission Primary Substance (PSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81, 91.	
A082	Admission Primary Substance of 10, 20, 41, 42, 45, 50-52 and Primary Initial Prescription equals 1 - Primary Substance can't be a prescription.	
A085	Admission Primary Substance and Secondary Substance are the same - PSA cannot be same as SSA.	
A088	All 3 Admission Substance values are the same - PSA, SSA, TSA cannot be the same.	
A107	Admission Primary Substance equals 00, Primary Route must be 0.	

Error #	Error Description	Field Name
A110	Admission Primary Substance equals 00 and Primary Age at First Use not equal 98.	
A027	Invalid Admission Primary Route - should be 0-5.	Primary Route
A028	Invalid Admission Primary Age at First Use - should be 00-98.	Primary Age at First Use
A067	Admission Primary Age at First Use greater than current age - Primary Age at First Use should be less than current age.	
A029	Invalid Admission Primary Frequency of Use - Should be 00 - 30 or 98.	Primary Frequency of Use
A093	Invalid Admission Primary Frequency of Use - if Primary Substance equals 00, Primary Frequency of Use must be 98.	
A030	Invalid Admission Primary Initial Prescription - should be 0 - 2.	Primary Initial Prescription
A031	Invalid Admission Secondary Substance e (SSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81, 91.	Secondary Substance
A083	Admission Secondary Substance of 10, 20, 41, 42, 45, 50-52 and Secondary Initial Prescription equals 1 - Secondary Substance can't be a prescription.	
A087	Admission Secondary and Tertiary Substance are the same - SSA cannot be the same as TSA.	
A091	Invalid Admission Secondary Substance - if PSA equals 00, SSA should be 00.	
A108	Admission Secondary Substance equals 00, Secondary Route must be 0.	
A111	Admission Secondary Substance equals 00, Secondary Age at First Use must be 98.	
A032	Invalid Admission Secondary Route - should be 0 - 5.	Secondary Route
A033	Invalid Admission Secondary Drug Age First Use - should be 00-98.	Secondary Age at First Use
A075	Admission Secondary Drug Age First Use greater than current age - Secondary Age at First Use should be less than current age.	
A034	Invalid Admission Secondary Frequency of Use - should be 00-30.	Secondary Frequency of Use
A094	Invalid Admission Secondary Frequency of Use - if Secondary Substance equals 00, Secondary Frequency of Use must be 98.	
A035	Invalid Admission Secondary Initial Prescription - should be 0-2.	Secondary Initial Prescription
A036	Invalid Admission Tertiary Substance (TSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81, 91.	Tertiary Substance
A084	Admission Tertiary Substance of 10, 20, 41, 42, 45, 50-52 and Tertiary Initial Prescription equals 1 - Tertiary Substance can't be a prescription.	
A086	Admission Primary Substance and Tertiary Substance are the same - PSA cannot be same as TSA.	
A087	Admission Secondary Substance and Tertiary Substance are the same - SSA cannot be same as TSA.	
A092	Invalid Admission Tertiary Substance - if PSA or SSA equals 00, TSA should be 00.	
A109	Admission Tertiary Substance equals 00, Tertiary Route must be 0.	

Error #	Error Description	Field Name
A112	Admission Tertiary Substance equals 00, Tertiary Age at First Use must be 98.	
A037	Invalid Admission Tertiary Route - should be 0 - 5.	Tertiary Route
A038	Invalid Admission Tertiary Age at First Use - should be 00-98.	Tertiary Age at First Use
A089	Admission Tertiary Age at First Use greater than current age - Tertiary Age at First Use should be less than current age.	
A039	Invalid Admission Tertiary Frequency of Use - should be 00-30.	Tertiary Frequency of Use
A095	Invalid Admission Tertiary Frequency of Use, if Tertiary Substance equals 00, Tertiary Frequency of Use must be 98.	
A040	Invalid Admission Tertiary Drug Initial Prescription - should be 0-2.	Tertiary Initial Prescription
A041	Invalid Admission Total Annual Income - should be 000000-999999, or blank.	Total Annual Income
A042	Invalid Admission Number of Dependents - should be 00-99 or blank.	Number of Dependants
A043	Invalid Admission Program Eligibility - Able to pay - should be 1 or 2.	Program Eligibility: Able to pay
A044	Invalid Admission Program Eligibility: Commercial insurance - should be 1 or 2.	Program Eligibility: Commercial insurance
A045	Invalid Admission Program Eligibility: Services contract - should be 1 or 2.	Program Eligibility: Services contract
A046	Invalid Admission Program Eligibility: Medicare - should be 1 or 2.	Program Eligibility: Medicare
A047	Invalid Admission Program Eligibility: Medicaid - Should be 1 or 2.	Program Eligibility: Medicaid
A048	Invalid Admission Program Eligibility: Workers compensation - Should be 1 or 2.	Program Eligibility: Workers Compensation
A049	Invalid Admission Program Eligibility: Other public sources - Should be 1 or 2.	Program Eligibility: other public sources
A050	Invalid Admission Program Eligibility: CA resources - Should be 1 or 2.	Program Eligibility: CA Resources
A141	Invalid Admission Program Eligibility: State Medical Plan - should be 1 or 2.	Program Eligibility: State Medical Plan
A051	Invalid Admission Program Eligibility:- MI Child - should be 1 or 2.	Program Eligibility: MI Child
A052	Invalid Admission Program Eligibility: Medicaid Children's Waiver - should be 1 or 2.	Program Eligibility: Medicaid Children's Waiver
A053	Invalid Admission Program Eligibility:- Other Program Eligibility - should be 1 or 2.	Program Eligibility: Other Program Eligibility Not Listed Above
A054	Invalid Admission Correctional Status - should be 00-10, 98.	Correctional Status
A055	Invalid Admission Total Arrests - 6 months - should be 00-99.	Total Arrests - 6 months
A061	Invalid Admission Total Arrests - 6 months - should be equal or greater than Admission Arrests -Possession/Sales - 6 months plus Admission Arrests - DUI/DWI - 6 months.	
A056	Invalid Admission Arrests - Possession/Sales - 6 Months - should be 00-99.	Arrests - Possession/Sales - 6 Months
A057	Invalid Admission Arrests - DUI/DWI - 6 months - should be 00-99.	Arrests - DUI/DWI - 6

Error #	Error Description	Field Name
		months
A058	Invalid Admission Total Arrests - 5 years - should be 00-99.	Total Arrests - 5 years
A062	Invalid Admission Total Arrests - 5 years - should be equal or greater than Admission Arrests - Possession/Sales - 5 years plus Admission Arrests - DUI/DWI - 5 years.	
A104	Invalid Admission Total Arrests - 5 years - should be equal or greater than Admission Total Arrests - 6 months.	
A059	Invalid Admission Arrests - Possession/Sales - 5 years - should be 00-99.	Arrests - Possession/Sales - 5 years
A063	Invalid Admission Arrests - Possession/Sales - 5 years - should be equal or greater than Admission Arrests - Possession/Sales - 6 months.	
A060	Invalid Admission Arrests - DUI/DWI - 5 years - should be 00-99.	Arrests - DUI/DWI - 5 years
A064	Invalid Admission Arrests - DUI/DWI s - 5 years - should be equal or greater than Admission Arrests - DUI/DWI - 6 months.	
A065	Invalid Admission Living Arrangement - should be 1-3	Living Arrangement
A074	Admission Living arrangement doesn't match County of Residence - if county is 96, then Living Arrangement must be 3 (homeless).	
A068	Invalid Admission Methadone Part of Treatment - should be 1 or 2.	Methadone Part of Treatment
A116	Invalid Admission Primary Diagnosis, must be a valid diagnosis code.	Primary Diagnosis
A097	Invalid Admission Primary Substance and Primary Diagnosis combination - Primary Diagnosis should match Primary Substance.	
A117	Invalid Admission Secondary Diagnosis format	Secondary Diagnosis
A066	Invalid Admission Pregnant value - Should be 1 or 2.	Pregnant
A070	If Admission pregnant equals 1, then sex must equal 2.	
A078	Invalid Admission Other Factor 1 - should be 0, 2-9, or blank.	Other Factor 1
A079	Admission Other Factor 1 equals Other Factor 2 - Other factor 1 and 2 cannot be the same.	
A080	Admission Other Factor 1 equals Other Factor 3 - Other factor 1 and 3 cannot be the same.	
A134	Invalid Admission Other Factor 2 - should be 0, 2-9 or blank.	Other Factor 2
A081	Admission Other Factor 2 equals Other Factor 3 - Other factor 2 and 3 cannot be the same.	
A076	Admission Other Factor 2 not blank or zero - if other factor 1 equals 0 or blank, Other Factor 2 should be zero or blank.	
A135	Invalid Admission Other Factor 3 - should be 0, 2-9 or blank	Other Factor 3
A077	Admission Other Factor 3 not blank or zero - If Other Factor 1 or Other Factor 2 equals 0 or blank, Other Factor 3 should be zero or blank.	
A096	Admission Time Waiting to Enter Treatment cannot be missing	Time Waiting to Enter Treatment
A136	Invalid Admission Primary Language Spoken.	Primary Language Spoken
A131	Invalid Admission Time of Day – should be valid time (24-hour)	Admission Time of Day

Error #	Error Description	Field Name
A098	Invalid Admission Error ID - should be 8-digit number or blank.	Error ID
A101	Invalid Admission Error ID - should be valid Error ID or blank.	

E.3 SA Discharge Data Element Edits

The following is the list of SA Discharge data element edits listed in the order of the input file format.

Note: All Errors reported in this document will cause the record to be rejected. Every Data Element having a detectable error will produce a copy of the Record in error with appropriate error messages appended. Error records will be stored in the SA Error Master Tables on the Oracle Database. These errors will be returned to the submitter via the 4827 file on the Data Exchange Gateway (DEG).

Error #	Error Description	Field Name
D001	Invalid Discharge Record Length - should be 105.	Input File
D098	No matching Discharge record - if Submission Type equals C or D, a matching record should exist.	Discharge Key CA Code, License Number, Social Security Number, CA Client ID, Admission Date, Admission Time of Day
D099	Discharge Submission Type equals A and a Discharge already exists - cannot add the Discharge.	
D101	Discharge Submission Type equals A and an Admission record does not exist - a valid Admission record must exit.	
D113	Discharge Submission Type equals A and an Admission exists and Discharge Date of Discharge/Discharge Time of Day not greater than Admission Date of Admission/Admission Time of Day - cannot add the Discharge.	
D108	Discharge Submission Type equals C and Discharge Date of Discharge/Discharge Time of Day being changed to less than or equal Admission Date of Admission/Admission Time of Day on prior Admission or greater than or equal Admission Date of Admission/Admission Time of Day on subsequent Admission - cannot process the change.	
D120	Discharge Submission Type equals C and a Discharge record not found - cannot process the change.	
D106	Discharge Submission Type equals D and an Admission record exists with an Admission Date of Admission/Admission Time of Day greater than the Discharge Date of Discharge/Discharge Time of Day - delete of Discharge would create two consecutive Admissions.	
D118	Discharge Submission Type equals D and a Discharge record does not exist - cannot process the delete.	
D002	Invalid Discharge Record Type - should be D.	Record Type
D125	Transition-out window is not open – Discharge record type is X and transition-out transactions are not currently allowed.	
D126	Transition-out record exists – Regular discharge record cannot modify transition-out record.	
D127	Discharge record exists – Transition-out record cannot modify regular discharge record.	
D003	Invalid Discharge Submission Type - should be A, C, D, E.	Submission Type

Error #	Error Description	Field Name
D102	Discharge CA Payer Identifier and Bureau ID do not match.	CA Code
D116	Invalid Discharge CA Code - not a valid CA Payer Identifier.	
D005	Invalid Discharge License Number - should be 6-digit.	License Number
D006	Invalid Discharge Social Security Number - should be 9-digits or blank.	Social Security Number
D117	Invalid Discharge CA Identifier - not permitted to be spaces or null.	CA Client Identifier
D008	Invalid Discharge Medicaid ID - should be 8-digit or blank.	Medicaid Identifier
D011	Invalid Discharge Date of Admission - should be valid date and less than current date.	Discharge Date of Admission
D069	Invalid Discharge Date of Admission/Admission Time of Day - should be less than Discharge Date of Discharge/Discharge Time of Day.	
D012	Invalid Discharge Service Category - should be 11, 21, 22, 24, 31.	Discharge Service Category
D122	Discharge service category does not match admission service category.	
D025	Invalid Discharge Employment Status - should be 1-4, 6, 8.	Employment Status
D026	Invalid Discharge Primary Substance (PSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81, 91	PSA Code Primary Substance
D084	Discharge Primary Substance and Secondary Substance are the same - PSA cannot be same as SSA.	
D087	All 3 Discharge Substance values are the same - PSA, SSA, TSA cannot be the same.	
D103	Discharge Primary Substance equals 00, Primary Route must be 0.	
D027	Invalid Discharge Primary Route - should be 0-5.	PSA Route Primary Route
D029	Invalid Discharge Primary Frequency of Use - Should be 00 - 30 or 98 and equal or less than the number of days between admission and discharge.	PSA Frequency of Use Primary Frequency of Use
D092	Invalid Discharge Primary Frequency of Use - if Primary Substance equals 00, Primary Frequency of Use must be 98.	
D031	Invalid Discharge Secondary Substance (SSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81, 91.	SSA Code Secondary Substance
D090	Invalid Discharge Secondary Substance - if PSA equals 00, SSA should be 00.	
D104	Discharge Secondary Substance equals 00, Secondary Route must be 0.	
D032	Invalid Discharge Secondary Route - should be 0-5.	SSA Route Secondary Route
D034	Invalid Discharge Secondary Frequency of Use - should be 00-30 or 98 and equal or less than the number of days between admission and discharge.	SSA Frequency of Use Secondary Frequency of Use
D093	Invalid Discharge Secondary Frequency of Use - if Secondary Substance equals 00, Secondary Frequency of Use must be 98.	

Error #	Error Description	Field Name
D036	Invalid Discharge Tertiary Drug (TSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81,91.	TSA Code Tertiary Substance
D085	Discharge Primary Substance and Tertiary Substance are the same - PSA cannot be same as TSA.	
D086	Discharge Secondary Substance and Tertiary Substance are the same – SSA cannot be same as TSA.	
D091	Invalid Discharge Tertiary Substance - if PSA or SSA equals 00, TSA should be 00.	
D105	Discharge Tertiary Substance equals 00, Tertiary Route must be 0.	
D037	Invalid Discharge Tertiary Route - should be 0-5.	TSA Route Tertiary Route
D039	Invalid Discharge Tertiary Frequency of Use - should be 00-30 or 98 and equal or less than the number of days between admission and discharge.	TSA Frequency of Use Tertiary Frequency of Use
D094	Invalid Discharge Tertiary Frequency of Use, if Tertiary Substance equals 00, Tertiary Frequency of Use must be 98.	
D054	Invalid Discharge Correctional Status - Should be 00-10, 98	Correctional Status
D055	Invalid Discharge Total Arrests - 6 months – should be 00-99.	Total Arrests - 6 months
D061	Invalid Discharge Total Arrests - 6 months – should be equal or greater than Discharge Arrests -Possession/Sales - 6 months plus Discharge Arrests - DUI/DWI - 6 months.	
D056	Invalid Discharge Arrests - Possession/Sales - 6 Months - should be 00-99.	Arrests - Possession/Sales - 6 months
D057	Invalid Discharge Arrests - DUI/DWI - 6 months - should be 00-99.	Arrests - DUI/DWI - 6 months
D065	Invalid Discharge Living Arrangement - should be 1-3.	Living Arrangement
D009	Invalid Discharge Date - Should be valid date and less than current date	Discharge Date of Discharge
D111	Discharge Date of Discharge is too old.	
D010	Invalid Discharge Reason - should be 01-11	Discharge Reason
D123	Invalid Admission Time of Day – should be valid time (24-hour)	Admission Time of Day
D124	Invalid Discharge Time of Day – should be valid time (24-hour)	Discharge Time of Day
D097	Invalid Error ID - Should be 8-digit number or blank.	Error ID
D100	Invalid Discharge Error ID - should be valid Error ID or blank.	

Appendix F Substance Abuse QI Error Return File

The SA QI Data Warehouse update programs normally run once daily and will include all unprocessed submissions through 7 AM. If the update programs run to completion by 10 AM, the SA QI error return files are generally available for extraction between 3 and 5 PM of the following day.

With the implementation of the SA QI data on the Encounter Data Warehouse, an error return file will be produced for each submitter. The file will contain the errors produced from the SA QI data element edits. The QI rejection/error file is to include all error/rejects stored on the SA Error Master Table on the Encounter Data Warehouse for a CA. The format of the error return file is as follows:

Note: All Errors reported on this document will cause the record to be rejected. Every Data Element having a detectable error will produce a copy of the Record in error with an appropriate error message appended. Error records will be stored in the SA Error Master Table on the Encounter Data Warehouse. These errors will be returned to the submitter via the 4827 file on the Data Exchange Gateway (DEG).

F.1 SA QI Error Return File Header

This SA QI Error Return File EDI Header record precedes the errors detected by the Encounter Data Warehouse edit process.

Field Name	Type	Size	Begin	End	Comments
EDI TYPE	Text	4	1	4	"HDDR"
EDI APP	Text	2	5	6	"MA"
EDI USER					
EDI USER - prefix	Text	5	7	11	"DCH00" (DCH zero zero)
EDI USER - CA ID	Text	2	12	13	Service Bureau ID
EDI USER - suffix	Text	1	14	14	Blank
EDI CREATION DATE	Text	8	15	22	CCYYMMDD
EDI TRANSFER DATE	Text	8	23	30	CCYYMMDD
EDI TRANSFER TIME	Text	4	31	34	HHMM
EDI FILE NAME	Text	4	35	38	4827
EDI RUN TYPE	Text	1	39	39	"P" for production or "T" for test
EDI BATCH IDENTIFIER	Text	3	40	42	Unique batch identifier assigned by CA
FILLER	Text	35	43	77	

F.2 SA QI Error Return File Data Element Errors

This SA QI record describes a record in which an error occurred during processing of one of the Substance Abuse QI files received via the DEG. Using the following key values, the exact record incurring an error is identified along with the field in error and the type of error.

Field Name	Type	Size	Begin	End	Comments
Record Code	Text	3	1	3	"ERR"
Record Type	Text	1	4	4	"A" for Admission "D" for Discharge "S" for SARF
Submission Type	Text	1	5	5	"A" for Add "C" for Change "D" for Delete "E" for Error
CA Code	Text	9	6	14	Identifies the entity submitting the transaction.
License Number	Text	6	15	20	CIS License Number
Social Security Number	Text	9	21	29	
CA Client Identifier	Text	11	30	40	Mandatory
Medicaid Identifier	Text	8	41	48	Blank if not applicable
Date of Admission	Date	8	49	56	
Error Number	Text	5	57	61	
Batch Sequence number	Numeric	8	62	69	Sequence number of the batch among all batches processed in the edit run.
Record Sequence Number	Numeric	8	69	77	Sequence number of the QI Admission record among all QI Admission records processed in the edit run.

F.3 SA QI Error Return File Trailer

This SA QI Error Return File EDI Trailer record follows the errors detected by the Encounter Data Warehouse edit process.

Field Name	Type	Size	Begin	End	Comments
EDI TYPE	Text	4	1	4	"TRLR"
EDI APP	Text	2	5	6	"MA"
EDI USER					
EDI USER - prefix	Text	5	7	11	"DCH00" (DCH zero zero)
EDI USER - CA ID	Text	2	12	13	Service Bureau ID
EDI USER - suffix	Text	1	14	14	Blank
EDI CREATION DATE	Text	8	15	22	CCYYMMDD
EDI TRANSFER DATE	Text	8	23	30	CCYYMMDD
EDI TRANSFER TIME	Text	4	31	34	HHMM
EDI FILE NAME	Text	4	35	38	4827
EDI RUN TYPE	Text	1	39	39	"P" for production or "T" for test
EDI BATCH IDENTIFIER	Text	3	40	42	Unique batch identifier assigned by CA
EDI RECORD COUNT	Number	6	43	48	Number of records in a file, including the header and trailer
FILLER	Text	29	49	77	